COMMONWEALTH OF KENTUCKY

Personnel Cabinet
Department for Employee Insurance

Administration Manual

Kentucky
UNBRIDLED SPIRIT

This manual has been designed to assist in the proper administration of the Kentucky Employees Health Plan (KEHP). It is intended for use by Insurance Coordinators agency personnel and KEHP members. All sample letters are available on the Department for Employee Insurance's (DEI) Web site. Insurance Coordinators may download the letters from the Web site and customize them for the individual agency's use. If the Insurance Coordinator does not have access to the Web site, please contact the DEI's Member Services Branch.

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INTRODUCTION

I Self-Funded

The Kentucky Employees Health Plan (KEHP) is a self-funded plan. The Commonwealth assumes the risk of our claims and pays an administrative fee to Humana, the KEHP's Third Party Administrator (TPA), and to Express Scripts, Inc., the Pharmacy Benefits Manager (PBM), to process claims and to access Humana's provider network.

II KEHP Partners

Humana and Express Scripts, Inc. have established relationships with several business partners to assist with the administration of the KEHP and to provide specialized services to our employees. These partners have been approved by the Commonwealth of Kentucky and comply with all privacy regulations.

- **Active Health Management** partners with Humana to offer Informed Care Management, Case Management and Utilization Management programs to the KEHP members.

- **Ceridian COBRA Continuation Services** partners with Humana to administer COBRA continuation services for KEHP members. Ceridian uses an online enrollment system called WebQE as the method for COBRA notification. All Insurance Coordinators must enter a member's new hire and COBRA QE information via WebQE. Ceridian is responsible for COBRA notification letters, enrollment, premium collection, and other COBRA related services.

- **CorpHealth, Inc**. partners with Humana to provide mental health and substance abuse services.

- **CuraScript Pharmacy** partners with Express Scripts to provide certain oral and injectable specialty medications. There are certain specialty drugs which are required to be filled through CuraScript. Members are allowed to fill the first prescription at the retail pharmacy. Express Scripts then advises the member that any future prescriptions are to be filled through CuraScript. CuraScript mails medications to the member's home, in addition to all needed supplies, at no additional cost.

TABLE OF CONTENTS

ELIGIBILITY AND ENROLLMENT

I Eligible Participants

NOTE: For purposes of this Administration Manual, the term "employee" includes full-time employees, retirees and/or beneficiaries, classified or certified school employees and COBRA participants.

NOTE: Employees, retirees or COBRA participants and/or their dependents may only be covered under **one** state-sponsored plan.

A. Full-time employees

Full-time employees of the following agencies who contribute to one of the state-sponsored retirement systems, or who are otherwise defined in KRS 18A.225, are eligible to participate:

State Agencies;
Boards of Education;
Health Departments;
Quasi Agencies; and
School Board Members (participate on a post-tax basis; members are responsible for total premiums).

B. Retirees

Retirees, **under age sixty-five (65),** who draw a monthly retirement check from any of the following retirement systems are eligible to participate according to plan guidelines:

- Judicial Retirement Plan;
- Legislators Retirement Plan;
- Kentucky Community and Technical College System (KCTCS);
- Kentucky Retirement Systems (KRS), which include:
  - County Employees Retirement System (CERS);
  - Kentucky Employees Retirement System (KERS);
  - State Police Retirement System (SPRS).
- Kentucky Teachers' Retirement System (KTRS).

KTRS retirees that have returned to active employment must select coverage through the active employer.

KTRS retirees who return to work may:

- **Waive** coverage with KTRS (i.e. receive no retirement insurance benefit) and **enroll** in a health insurance plan (including Commonwealth Select) through their employer; **or**
- **Waive** coverage with KTRS (i.e. receive no retirement insurance benefit) and **enroll in the stand-alone HRA** through their employer.

KRS retirees that have returned to active employment have the option to select coverage either through KRS or through the active employer.

KRS retirees who return to work may:

- **Enroll** in a health insurance plan with KRS and **waive** coverage through their employer but **not enroll in the stand-alone HRA**;
- **Waive** coverage with KRS (i.e. receive no retirement insurance benefit) and **enroll** in a health insurance plan (including Commonwealth Select) through their employer; or
- **Waive** coverage with KRS (i.e. receive no retirement insurance benefit) and **waive** coverage through their employer and **enroll in a stand-alone HRA**.

Retirees 65 and older who return to work

Retirees 65 and older who are receiving KRS or KTRS funds toward a Medicare Supplemental plan, are **NOT** eligible to receive state funding through the active employer for either a stand-alone HRA or an insurance plan. If they waive coverage through their active employer, they will not receive an HRA. In addition, if they select an insurance plan through their employer, they will not receive state funding toward the cost of the plan.

SPOUSES OF HAZARDOUS DUTY RETIREES

Spouses of hazardous duty retirees who are covered under the hazardous duty retiree's plan and who are actively employed, are not eligible to waive coverage and receive the employer contribution into an HRA due to KRS 18A.225 (12), which reads as follows:

> *Any employee who is eligible for and elects to participate in the state health insurance program as a retiree, or the spouse or beneficiary of a retiree, under any one (1) of the state-sponsored retirement systems **shall not** be eligible to receive the state health insurance contribution toward health care coverage as a result of any other employment for which there is a public employer contribution. This does not preclude a retiree and an active employee spouse from using both contributions to the extent needed for purchase of one (1) state sponsored health insurance policy for that plan year.* (Emphasis added).

C. COBRA qualified beneficiaries

D. Dependents

Dependents, who meet the following dependent eligibility requirements, are eligible for participation under the Kentucky Employees Health Plan (KEHP).

A dependent is:

- A member's spouse under an existing legal marriage;
- A member's dependent child;

Congress made changes to the definition of dependent for tax purposes, which may affect the eligibility of a member's dependents for their health insurance coverage. Congress divided dependent into a "Qualifying Child" and a "Qualifying Relative".

- For purposes of our health insurance Plan, a "Qualifying Child" is a member's child, stepchild, adopted child, foster child or grandchild (see Supporting Documentation guidelines in Chapter 3, section IV), who lives with the member for more than half of the taxable year, is less than 19 years of age at the end of the NEXT calendar year and will not provide over one-half of his own support during the calendar year.
  - A foster child must have been placed by an authorized agency or by judgment, decree or court order.
  - Temporary absences, such as for school, are permitted.
  - A child will remain eligible beyond the 19th birthday if he/she will be less than 24 years of age at the end of the NEXT calendar year.
  - Age restrictions do not apply to a child that is permanently and totally disabled. (See next page for more details)

- For purposes of our health insurance Plan, a "Qualifying Relative" is a member's child, stepchild, adopted child, foster child or grandchild (see Supporting Documentation guidelines in Chapter 3, section IV), who lives with the member for more than half of the taxable year, is less than 24 years of age at the end of the NEXT calendar year and for whom the employee will provide over one-half of his support.

- For purposes of our health insurance Plan, a child who does not live with the member, but for whom the member or his/her spouse has a legal obligation under a divorce decree, court order or administrative order to provide the health care expenses of the child, remains eligible for coverage as a "Qualifying Child" or "Qualifying Relative", depending on the child's age.

  Dependents may only be covered under one (1) state sponsored plan. The employee with custody shall have first option to cover the dependent children, unless both employees agree otherwise in writing.

- For purposes of our health insurance Plan, an unmarried disabled dependent may ***continue*** to be covered under the Plan beyond the age limit if the disability started before the limiting age and is medically

certified by a physician. A disabled dependent not covered under the Plan prior to the limiting age due to having other health insurance coverage may be enrolled in the KEHP if he/she **loses** the other health insurance coverage.

A total disability is defined as the condition that results when any medically determinable physical or mental condition prevents a dependent from engaging in substantial gainful activity and can be expected to result in death or to be of a continuous or indefinite duration. The KEHP's Third Party Administrator may require proof of the dependent's disability at least annually.

If an eligible disabled dependent has not been coded as a disabled dependent (DD) on the Enrollment Application or form prior to reaching the limiting age, the child will be automatically dropped from the Plan at the end of the calendar year in which he/she turns 23. In order to code a child as a DD at that time, the KEHP's Third Party Administrator will request a physician's statement attesting to the dependent's disability. The physician's statement will be submitted to the Third Party Administrator (TPA) for review and approval.

If, during Open Enrollment, a member wishes to enroll a disabled dependent that is past the limiting age, the member must show proof that the disabled dependent has experienced a loss of coverage. The request to add the disabled dependent must be made within thirty (30) calendar days of the qualifying event (QE).

The Insurance Coordinator will be notified of the TPA's determination. If approved, coverage for the disabled dependent will be processed by the DEI.

II Employer Contribution

A. State agencies, boards of education and health departments

In order to be eligible to receive the employer contribution, employees must meet one of the following:

- Full-time employees are eligible for the employer contribution for the following month after the initial waiting period for new hire, if during the month, they use:
  - any combination of workdays;
  - paid leave; and/or
  - Family Medical Leave (Refer to Chapter 6 for additional information on FMLA).

- Employees that are unable to work and elect to use paid leave to qualify for the employer contribution must use those days consecutively.

- Employees returning from leave without pay (LWOP) must work at least one day in the month to qualify for the employer contribution for the following month (refer to Chapter 6 for additional information on LWOP).

- Employees who have exhausted paid leave and FMLA shall not qualify for the employer contribution for health benefits unless they work at least one day in the previous month.

B. Quasi governmental agencies

Insurance Coordinators for quasi-governmental agencies should refer to their administrative regulations or internal policies for the definition of a full-time employee.

C. Dual employment

Employees who are considered full-time for two (2) participating employers (and meet the eligibility requirements for both employers) are eligible for the employer contribution from each. However, employees are only eligible for health insurance coverage under one state-sponsored plan. Therefore, dual employees may take health insurance through one employer and waive coverage through the other employer and enroll in a Health Reimbursement Account (HRA).

III Levels of Coverage

- **Single** – covers the employee only.
- **Parent Plus** – covers the employee and one or more eligible children.
- **Couple** – covers the employee and the employee's spouse only.
- **Family** – covers the employee, spouse and one or more eligible children.

IV Cross-Reference Payment Option

Cross-reference is a payment option available to two (2) legally married participating members in the KEHP. ***A family cross-reference payment option terminates when one of the participating employees terminates employment or begins a leave of absence without pay; however, the level of coverage (family) will remain the same. The remaining eligible employee will pay the full employee premium of the family plan. As the Insurance Coordinator, you should explain this to any employee selecting the family cross-reference payment option.*** The remaining employee will be allowed to select a different plan option, if requested within the deadline (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Select, or Commonwealth Premier).

A. Family plan

Two (2) married, eligible members of the KEHP may enroll themselves and their eligible dependent children in a family plan and elect the cross-reference payment option. The cross-reference employee contribution, if any, will be deducted from each member's paycheck.

B. Cross-reference requirements

To be eligible to select the cross-reference payment option with a family plan, each of the following requirements must be met:

- The members must be legally married (husband and wife);
- The members must be eligible employees or retirees* of a group participating in the KEHP;
- The members must elect the same coverage; and
- The Enrollment Application must be completed, signed, and dated by the deadline by **both** members and filed with their employers' Insurance Coordinators. Both Insurance Coordinator signatures must be on the form.

Failure to meet any one of the above requirements will make the employees ineligible for the cross-reference payment option.

**Members of the Judicial and Legislators Retirement Plans are not eligible to elect the cross-reference payment option.*

C. When can the cross-reference payment option be selected?

Employees may select the cross-reference payment option at the following times:

- During the Open Enrollment period;
- At the time of hire with a participating group - **the newly hired employee must elect coverage to match the existing employee/retiree's elections and the existing employee becomes the plan holder. If the existing member has waived health insurance, the member, newly hired spouse, or dependent must have experienced a loss of coverage and sign and date the Enrollment Application requesting to begin a cross-reference payment option within 30 calendar days of the loss. Depending on how the dates fall, the existing member may have to pay full family premium for the first month;**
- At retirement – newly retired members of a participating retirement system can elect a cross-reference payment option, if applicable. **The new retiree must elect coverage to match the existing employee/retiree's elections and the existing employee becomes the plan holder.** Retirees are not eligible for the Commonwealth Select Plan; or
- During certain qualifying events (QE) - When two (2) employees experience a QE, which will allow their plans to merge into one (1) cross-reference payment option, one or both employees may change their plan option (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier or Commonwealth Select) in order to start a cross-reference payment option.

NOTE: If a member's spouse's employer joins the KEHP as a new group during the Plan Year, the member and their spouse WILL NOT be allowed to elect a cross-reference payment option because no QE has occurred.

D. Ending the cross-reference payment option

Employees will not be eligible to continue the cross-reference payment option if any of the following events occurs:

- Termination of employment or beginning of leave of absence without pay – if one of the members in a cross-reference payment option terminates

employment or begins a leave of absence without pay, **the cross-reference payment option will terminate.** The employee terminating employment or beginning a leave of absence without pay has not experienced a loss of coverage; therefore, a plan level change is not permitted. However, the remaining member may request an option change (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier or Commonwealth Select). The terminating employee is no longer eligible to receive an employer contribution; therefore, **the remaining member will be responsible for the payment of the full employee family premium;** or

- New retirement – newly retired members of a participating retirement system can elect to stop their cross-reference payment option. The spouse of the new retiree will be enrolled in a coverage level that corresponds to the new retiree's elections*; or
- Experiencing a QE that allows members to drop their spouse – changes in plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier or Commonwealth Select) will be allowed; or
- Experiencing a QE that allows members to drop their only dependent child – in this situation, the covered members will be assigned to two (2) single plans. Changes in plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier or Commonwealth Select) will be allowed.

Note: An employee in a cross-reference payment option who terminates employment is not eligible for COBRA coverage. Do not enter these employees in Ceridian's WebQE.

*Retirees are not eligible for the Commonwealth Select Plan.

V Initial Enrollment

Coverage for new employees will begin on the first day of the second calendar month following the employees' hire date. For example, if employment begins anytime in August, the employees are eligible for coverage October 1.

New employees must complete, sign, and date a new application to apply for coverage or waive their coverage within the first thirty (30) calendar days of employment.

Employees who fail to make their health insurance elections or waive their coverage within thirty (30) calendar days will not have coverage and will not be allowed to enroll until the next Open Enrollment period, unless an appropriate qualifying event occurs. When **employees fail to enroll, the Insurance Coordinator must submit an Enrollment Application indicating that the employees have waived coverage but are not enrolled in the stand-alone HRA (this is often referred to as a "forced waiver").** The Enrollment Applications may be sent to the DEI or entered via the web enrollment system.

The Group Health Insurance (GHI) and the web enrollment systems counts exactly **thirty (30) calendar days** beginning with the day after the hire date.

NOTE TO INSURANCE COORDINATORS OF QUASI-GOVERNMENTAL AGENCIES:
Refer to your administrative regulations or internal policies. If your probationary period for benefits eligibility is longer than described above for state agencies, boards of

education, and health departments, the employees must sign the Enrollment Application no earlier than sixty (60) days prior to the effective date and **no later than thirty (30) days prior** to the effective date of coverage. Employees who fail to make their health insurance elections or waive their coverage within the deadline will not have coverage and will not be allowed to enroll until the next Open Enrollment period, unless an appropriate qualifying event occurs. For instance, if your agency has a six (6) month waiting period before health insurance coverage is effective and the employee is hired on January 1, the employee must sign the application no earlier than May 1 and no later than June 1 (between May 1 and May 30) in order to be effective July 1. Employees who transfer from another agency within the KEHP who have a 0-29 day break **will not have a break in insurance coverage**. The quasi agency must ensure that coverage for the employee is effective **without a break**. The employer contribution must be provided accordingly.

VI Waiving Coverage

A. Waivers with an HRA (stand alone HRA) will only be accepted:

- During the annual Open Enrollment period;
- From new employees;
- From employees with a thirty (30) or more calendar day break in service (in employment);
- From employees who experience a different open enrollment that occurs between the KEHP's open enrollment and 12/31; or
- From employees returning from Military Leave who are remaining on Tricare.

To waive coverage, employees must complete all applicable sections of the Enrollment Application.

B. Redirection of the employer contribution

- **When can employees change from a waiver with a stand alone HRA to a health insurance plan?**

  Employees who are enrolled in a stand alone HRA will only be allowed to stop the HRA and enroll in a health insurance plan **if they experience a QE that would allow them to enroll** (all QE guidelines apply).

  - A QE that allows members to enroll in the Plan also allows members to stop their stand-alone HRA and ***redirect*** the employer contribution toward a health insurance plan.
  - For purposes of our health insurance plan, redirection is the ability of an employee to stop employer funds from going into a stand-alone HRA in order to start receiving an employer contribution toward a health insurance plan as a result of experiencing a permitted qualifying event (QE).
  - An employee's employer contribution is considered to be 1) $175 monthly toward an HRA or 2) the employer paid portion of the health insurance premium.
  - Active employees, age 65 or older, that wish to be covered by Medicare only, may waive health insurance coverage if the

appropriate form is signed and dated by the members no later than thirty (30) calendar days after their Medicare eligibility date (Refer to the TEFRA Letter in Appendix A).
- Retirees who return to active employment are not eligible for the HRA unless waiving coverage with both the retirement system and the active employer. Refer to section I, B, Retirees.

- **When can employees terminate a health insurance plan in order to enroll in a stand alone HRA?**

  Employees who are enrolled in a health insurance plan **will not** be allowed to terminate coverage and enroll in a stand alone HRA in the middle of a plan year, unless:
  - They are new employees or have a 30 or more break in service;
  - They experience a different open enrollment period that occurs between the KEHP's open enrollment and 12/31; or
  - They are returning from military leave and remaining on Tricare.

C. Waiver with no HRA (Forced Waiver)

Employees, who do not complete, sign and date an Enrollment Application within thirty (30) calendar days from their date of hire (or thirty (30) calendar days before their effective date for some quasi-governmental groups) or during the Open Enrollment period will not have health insurance. They will not be eligible to enroll until the next Open Enrollment period or until they experience a qualifying event that would allow them to enroll.

The Insurance Coordinator must submit an Enrollment Application for a waiver with no HRA (forced waiver) to the DEI or waive coverage via the web enrollment system.

VII Open Enrollment

Open Enrollment is a period of time for employees to make plan elections for the upcoming Plan Year. Open Enrollment requirements may vary during each Open Enrollment period. Therefore, the DEI will provide specific Open Enrollment guidelines to all members during each period.

After Open Enrollment elections have been made, employees may only change their elections under very specific circumstances. Such changes are regulated by federal law and are referred to as "permitted election changes" under the federal regulations. DEI refers to these events as qualifying events. The requested change must always be consistent with the qualifying event.

VIII Coverage Changes

If an employee experiences a permitted election change as defined in the federal regulations, an employee must submit the appropriate supporting documentation according to the guidelines in Chapter 3, section IV. The appropriate paperwork must be signed and dated by the employee(s) within the specified timelines in Chapter 3, section V. If the timeline is exceeded, the request for change will be denied.

IX Transition from Dependent to New Employee

Dependent children that are already covered as dependents in the KEHP and become employed by a participating employer have the following options upon hire:

A. Become Planholders

The dependent children:

- Must complete, sign, and date an Enrollment Application as new employees; and
- Will be dropped from the parents' plan on the day prior to the effective date of their coverage as planholders.

NOTE: The planholder does not need to complete a Dependent Drop Form to drop the dependent.

If the child being dropped is the only dependent child on the plan, the DEI will automatically assign the parent's coverage as follows:

- A parent plus plan will be changed to a single plan; or
- A family plan will be changed to a couple plan.

In addition, neither the couple cross-reference payment option, nor the single Commonwealth Essential plan is available. Therefore, the following guidelines will be applied:

- A family cross-reference payment option will become two single plans;
- Commonwealth Essential plans will become Commonwealth Enhanced plans.

The DEI will notify the parent's Insurance Coordinator of this action. The Insurance Coordinator must notify the parent(s).

B. Remain as dependents on their parent's plan

If, upon hire, covered dependents still meet the dependent eligibility requirements, the affected parties must do the following:

- The newly hired dependent child must complete an Enrollment Application to waive coverage no later than thirty (30) calendar days from date of hire; and
- The newly hired dependent child must also submit a notarized letter from the parent(s), as explained below:
    - The parents, under whom the new employee is still covered as a dependent child, must provide the DEI with a written request to keep the child enrolled in their plan. The request must be notarized and it must state that the child still meets all dependent eligibility requirements of the Plan **after employment**. If the

required documentation is not received by the DEI with the dependent child's application to waive coverage, the DEI will automatically terminate the child's coverage as a dependent and will process the waiver. If the application for a stand-alone waiver is signed and dated within thirty (30) calendar days of employment, the new employee will be enrolled in the HRA.

X New Employees, Transfers and Rehires

New Employees are employees newly hired by your agency. They may or may not have worked for another KEHP participating agency as of the business day prior to their hire date with your agency.

In order to determine the effective date of coverage with your agency and whether or not your newly hired employees are allowed to make changes to their health insurance elections, review the scenarios below:

A. Your newly hired employees did not work for a KEHP participating agency prior to their employment with your agency.

Under this scenario, the following apply:

- The effective date of their health insurance elections is the first day of the second calendar month following their hire date. For example, if employment begins anytime in August, the employees are eligible for coverage October 1. (See section V, Initial Enrollment, for details)
- The newly hired employees are allowed to enroll in any available plan or waive health insurance coverage and enroll in an HRA, if eligible (all enrollment procedures, deadlines and restrictions apply).

B. Your newly hired employees are transferring directly from another KEHP participating agency without a break in service (in employment).

Under this scenario, the following apply:

- The effective date of their health insurance elections is the first day of the month following their termination date of coverage with the previous agency. This may require your agency to begin providing the employer contribution for the month following the employees' hire date. For example, if employment begins anytime in August and their coverage with the previous employer terminated August 30, your agency must provide coverage and the employer contribution for the month of September.
- The newly hired employees are NOT allowed to make new health insurance elections. The Insurance Coordinator must submit an Update Form reinstating their prior elections. Employees will be allowed to make new coverage elections only if they have experienced a qualifying event (all QE guidelines apply). If this is the case, the employees must submit an Enrollment Application requesting the permitted change(s).

- There may be some employees that terminate employment at one agency at the end of a week (before a weekend) and begin employment with the new agency at the beginning of a working week (usually Monday), or during a holiday. Employees in that situation will be considered to have had no break in service (in

employment) because weekends and/or holidays are not regularly scheduled working periods.

NOTE: Some employees' weekends are not Saturday/Sunday. Their weekend may fall in the middle of the week. In that case, those regularly scheduled days off would not count as a break in service.

C. The newly hired employees are transferring from another KEHP participating agency and have experienced a break in service (in employment). Under this scenario, the following apply:

a. If the break in service is 0-29 calendar days.

- These newly hired employees are considered transfers.
- They will not experience a break in health insurance coverage.
- They are NOT allowed to make new health insurance elections. The Insurance Coordinator must submit an Update Form reinstating their prior elections.
    - Employees will be allowed to make new coverage elections only if they experienced a qualifying event (all QE guidelines apply) or if an Open Enrollment period occurred during the break in service. If this is the case, the employees must submit an Enrollment Application requesting the permitted change(s).

b. If the break in service is thirty (30) calendar days or more, the following apply:

- These newly hired employees are considered new employees.
- The effective date of their health insurance elections is the first day of the second calendar month following their hire date. For example, if employment begins anytime in August, the employees are eligible for coverage October 1. (See section V, Initial Enrollment, for details)
- The newly hired employees are allowed to enroll in any available plan, waive health insurance coverage and enroll in an HRA if eligible, make changes to smoking status if needed, (all enrollment procedures, deadlines and restrictions apply. See section V, Initial Enrollment, for details).
- Example:
    - A KEHP participating employee terminates employment on 2/19 with coverage ending on 3/31. Employee is hired by another KEHP participating agency on 3/27 (*thirty-six (36) days break in service*). Insurance elections must be effective with the new agency on 5/1 (*the first day of the second calendar month following the hire date*). The employee is allowed to make new coverage elections and changes to smoking status.

c. If the break occurs before insurance goes into effect:

- If the newly hired employees (transfer) miss no workdays, their insurance elections will go into effect as scheduled with the prior agency.
    - There will not be another waiting period.

- The newly hired employees are NOT allowed to make new health insurance elections. The Insurance Coordinator must submit an Update Form reinstating their prior elections.

- If the newly hired employees (transfer) miss one (1) workday or more, a new waiting period will be applied.
  - The newly hired employees are allowed to enroll in any available plan, waive health insurance coverage and enroll in an HRA if eligible, make changes to smoking status if needed, (all enrollment procedures, deadlines and restrictions apply. See section V, Initial Enrollment, for details).
- Example:
  - An employee begins working at the Transportation Cabinet in January with an insurance effective date of March 1. He quits on Friday, Feb. 15 and begins working with the Personnel Cabinet on Monday, February 18. His insurance will go into effect on March 1 as scheduled with no changes to his original insurance elections. If, however, he does not begin work with the Personnel Cabinet until Tuesday, February 19, his insurance will go into effect April 1. Changes will be allowed.

XI Summer Transfers among Boards of Education

A. Employees Not Working Summer Months and Given a Termination Notice (Pink Slip) at the End of Their Contract:

a. Insurance Coordinator Responsibility of Original Agency:

- EVERY employee who receives a pink slip shall be terminated by the Insurance Coordinator effective 6/30 (with an insurance termination date of 7/31). To make the process easier, the IC of that district will send to the Enrollment Information Branch one list that includes all names and social security numbers of those individuals instead of sending Update Forms for each individual.
- If the termed employee is rehired by the original agency, the IC will send an Update Form to EIB indicating the reinstatement with no break in coverage.

b. Insurance Coordinator Responsibility of New Agency:

- Board of education employees who complete their contract (ex. 6/30) with their agency and transfer to another board beginning the next contract date (ex. 8/1) during the summer months are considered to have experienced NO break in service (in employment). They must work the first day of school in order to have no break in health insurance coverage.
- No matter when the employee transfers to the new district, the new district will pick up the new insurance for the transferred employee effective 8/1. The IC for the new agency will send an Update Form indicating the transfer with an insurance effective date of 8/1.
- If the new agency is unaware that the employee has transferred, the EIB will make a correction to the effective date to ensure no break in coverage and will notify the agency IC of such correction.
  NOTE: This scenario is based on the assumption that there is no break in service.

Page Updated April 2008

B. Employees Who Did Not Receive a Termination Notice at the End of Their Contract:

a. Insurance Coordinator Responsibility of Original Agency:

- If an employee transfers to a new district during the summer and the district from which they transferred (old district) has already withheld insurance deductions, the deductions will continue to be submitted by the old district as if the employee were still in that district.

b. Insurance Coordinator Responsibility of New Agency:

- The district to which the employee transferred (new district) is responsible for setting a health insurance effective date that will reflect those withholdings from the old district. Example: Insurance was withheld in the old district to cover the August payment for September coverage. The IC for the new agency will send an Update Form indicating the transfer with an insurance effective date of 10/1.
- If the new agency is unaware that the employee has transferred, the EIB will make a correction to the effective date to ensure no break in coverage and will notify the agency IC of such correction.

  Note: They must work the first day of school in order to have no break in health insurance coverage.

C. Year Round Employees (all other staff)

- Will be just like a twelve (12) month employee transferring during any other time of the year such as during February.
- In the case of a twelve (12) month employee, the district that the employee is transferring from will continue coverage through the end of the month following the month of termination. The district that the employee is transferring to will pick up the employee effective the first day of the month following the month of employment. This scenario is based on the assumption that there is no break in service.

XII Coverage Terminations

A. Termination of employment

Health insurance coverage for employees terminating employment will be provided through the end of the month following the month of termination. For example, if employment ends anytime in August, the employee is eligible for coverage through the end of September. Employees are subject to the following provisions:

- The employee's contribution will be deducted automatically from the employee's check. In the event there is not enough money in the last paycheck to cover the premium, agencies should collect from the individual or deduct the remainder from the payout of vacation or compensatory pay.
- Employees that terminate employment before their benefits take effect are not eligible for those benefits and therefore, not eligible for COBRA.

- The Insurance Coordinator may terminate the employee via the KEHP's web enrollment system or submit a Health Insurance Update Form listing the employee's termination date of employment and the termination date of coverage.
- The Insurance Coordinator will enter the termination information on Ceridian's WebQE to initiate Ceridian to mail COBRA information to the affected employee and dependents.
- Terminated employees that were enrolled in a cross-reference payment option are not eligible for COBRA. The employee will remain on the spouse's plan. The spouse will pay the entire employee contribution for the family plan.

B. Procedures for the retirement systems

a. Medicare Eligible Retiree with Couple, Family or Parent Plus plan

- Retiree becomes Medicare Eligible
  - Plan terms end of month (day before Medicare Eligible)
  - Dependent can apply (within 30 calendar days from Medicare Eligibility date) to take over plan on 1st day of month after Retiree's coverage ends
  - No break in coverage
- Spouse/dependent (PH) who took over the plan above dies leaving dependent(s) on the plan
  - Plan terms end of month of date of death
  - Dependent can apply (within 30 calendar days from date of death) to take over plan on 1st day of following month after date of death

***NOTE: In both cases above, the Retiree (XH) is not deceased**

b. Medicare Eligible Retiree with Single plan

- Retiree becomes Medicare Eligible
  - Plan terms end of month (day before Medicare Eligibility date)

When retirees reach age 65, they will receive a letter stating whether or not they are Medicare eligible. Regardless of their enrollment status in Medicare, retirees who become eligible for Medicare are no longer eligible participants of the KEHP. See KRS 18A.225. The Insurance Coordinator must send an Update Form to DEI terminating the retiree due to Medicare eligibility. If the Medicare letter states that the retiree does not qualify for Medicare, the retirement Insurance Coordinator must submit the letter to the DEI in order to show that the retiree is still qualified to remain on the Plan.

Note: Eligibility for partial benefits also constitutes Medicare eligibility. Although some retirees may choose to defer drawing benefits until a later date, they are still ineligible to participate in the KEHP and their KEHP coverage must be terminated.

c. Retiree with Couple, Family or Parent Plus plan

- Dependent on the plan dies, dependent terms date of death
  - New plan (if applicable) will be effective the day after the dependent's date of death

- Retiree dies
  - plan terms end of month
  - Beneficiary can apply (within 30 calendar days from date of death) to take over plan on 1st of month following date of death
  - KRS must submit supporting documentation indicating the person named as beneficiary
- Beneficiary (PH) dies Single Coverage
  - Plan terms date of death
- Beneficiary (PH) with Dependents dies
  - Plan terms end of month

A retiree's dependent(s) may "take over" the policy as the planholder. The retiree's dependent must elect the coverage within thirty (30) days of the retiree's death. The IC should submit an application to DEI with the new planholder's insurance elections. The effective date of the new plan will be the first day of the month after date of death if the beneficiary applies for continuation of coverage. The retirement system will provide a copy of the Beneficiary Form to the DEI as proof of eligibility to take over the plan. This will be the case regardless of when the death occurs in the month. No refunds will be issued by the DEI. If the retiree's beneficiary does not apply to take over/continue the coverage, the coverage will end at the end of the month of death.

d. Retiree with Single Coverage

- Retiree dies
  - Plan terms date of death
  - Beneficiary can apply (within 30 calendar days from date of death) to take over plan on 1st day of following month after signature date on the application
  - KRS must submit supporting documentation indicating the person named as beneficiary
- Beneficiary (PH) dies Single Coverage
  - Plan terms date of death
- Beneficiary (PH) with Dependents dies
  - Plan terms end of month

The deceased retiree's beneficiary (the individual designated by the retiree as his or her beneficiary, or filed with the retirement system) may apply to enroll in the health plan when he/she experiences a qualifying event that would allow the beneficiary to enroll (such as loss of other coverage) or during Open Enrollment. The death of the retiree in itself is not a QE that would allow the beneficiary to enroll in the plan.

C. Death of employee

The employer contribution for health insurance will end the month of the employee's death. If the next month's contribution has been made, a refund must be requested.

- Health insurance coverage ends on the date of death if the employee had no dependents under the Plan.
- Health insurance coverage ends at the end of the month of death if the

employee had dependents under the Plan.

At the time of death, the Insurance Coordinator should notify the family, in writing, of the following:

- Date the last paycheck will be issued;
- Contact information for the appropriate retirement system;
- Name and phone number of the Plan's administrator;
- Flexible Spending Account information and phone number (if applicable); and
- Additional employee payroll deductions and agency contacts.

You will also need to enter the QE on Ceridian's WebQE.
(See the COBRA Chapter for more information about Ceridian's WebQE)

D. Loss of dependent eligibility

Dependent children and/or spouses who become ineligible for coverage under the Plan (other than for attaining the limiting age) will be terminated at the end of the month they cease to meet the dependency requirements, whether the thirty (30) day requirement has been met or not.

Dependent children who become ineligible under the Plan due to attaining the limiting age will be terminated at the end of the calendar YEAR **before** attaining the limiting age. For example, coverage for dependent children who turn 24 in May 2008 will terminate on December 31, 2007. In this example, the dependent children will not be able to enroll in the Plan in 2008 or thereafter.

XIII Retro Activity Related to Premiums

Any mid-year election change resulting in the termination of a covered person will be effective on the date as designated under the terms of the KEHP. Refunds will be restricted to the beginning of the current plan year to a maximum period of three (3) months or ninety (90) days, except in the event of the death of a covered person.

For specific information regarding refund requests, refer to Chapter 7, Premium Billing and Reconciliation.

GENERAL ADMINISTRATION

Page Updated April 2020

I Appeal Procedures

A. Appeals to the Third Party Administrator (TPA)

Humana, the TPA for the Kentucky Employees Health Plan (KEHP), has a two-level internal appeals procedure. Appeals to the TPA include, but are not limited to: medical claims rejections, medical claims adjudication, medical prior authorization denials, medical provider networks, etc.

B. Appeals to the Pharmacy Benefits Manager (PBM)

Express Scripts, Inc. (ESI), the PBM for the KEHP, has a one-level internal appeals procedure. Appeals to the PBM include, but are not limited to: pharmacy prior authorizations, pharmacy step therapy, pharmacy Quantity Level Limit (QLL), pharmacy refill frequency, pharmacy provider networks, etc.

C. Appeals to the Kentucky Office of Insurance (KOI)

The KOI will be available to provide coverage denial reviews after KEHP members have exhausted the TPA and/or the PBM's internal levels of appeals.

D. External Review appeals

KEHP members have the right to appeal medical necessity determinations to an independent review entity after the TPA and/or the PBM's internal levels of appeals.

E. Grievances and appeals to the KEHP

1. Eligibility & Enrollment Grievance Committee

Members who are dissatisfied with a decision regarding enrollment or termination in the KEHP may file a grievance to the KEHP's Grievance Committee. Members must file grievances no later than thirty (30) calendar days from the event or notice of the decision being protested. Grievances must be filed in writing to:

Personnel Cabinet
Department for Employee Insurance
Attention: Grievance Committee
501 High Street, 2nd Floor
Frankfort, KY 40601

Grievances must include ALL of the following items:

- Member's name and Social Security Number, and agency name;
- A description of the issue(s) disputed by the member;
- A statement of the resolution requested by the member;
- All other relevant information; and
- All supporting documentation.

Grievances without all necessary information will be returned without review.

A written response will be mailed to the employee and to the agency's health Insurance Coordinator stating the decision of the Committee.

The Committee will not review a second request **unless** additional relevant facts are provided.

Note:

- Non-covered benefits or non-covered prescriptions are not appealable to the Grievance Committee.
- The Grievance Committee will only review grievances regarding enrollment and/or eligibility.

2. Administrative Appeals Committee

Members who are dissatisfied with a formulary change decision may file an appeal to the KEHP's Administrative Appeals Committee. Members must file the appeal no later than sixty (60) days from the date of the notice of the formulary change.

Appeals must include ALL of the following items:

- Member's name and Social Security Number, and agency name;
- A description of the formulary change being disputed by the member;
- A physician's statement which states that the member's physician is of the opinion that the member continue to take the drug as before the formulary change;
- All other relevant information; and
- All supporting documentation.

Appeals must be filed in writing to:

Personnel Cabinet
Department for Employee Insurance
Attention: Administrative Appeals Committee
501 High Street, 2nd Floor
Frankfort, KY 40601

II Fraud

If the TPA, the PBM, and/or the KEHP believe that any fraudulent activity has occurred, they are authorized to investigate and resolve issues arising from the fraudulent activity. Any person who knowingly, and with the intent to defraud any insurance agency or other person, files an application for insurance containing any incorrect information or a forged or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. Any material misrepresentation may be used to reduce or deny a claim or to terminate coverage.

III Double Dipping

Employees (or their spouse) that are eligible for and participate in the KEHP as retirees (or as the spouse or beneficiary of a retiree) and as employees (or spouses), are permitted to have only one employer contribution. They are not allowed to receive a contribution as retirees and a second contribution as employees. Specifically, KRS 18A.225 (12) addresses it as follows:

> "Any employee who is eligible for and elects to participate in the state health insurance program as a retiree, or the spouse or beneficiary of a retiree, under any one (1) of the state-sponsored retirement systems shall not be eligible to receive the state health insurance contribution toward health care coverage as a result of any other employment for which there is a public employer contribution. This does not preclude a retiree and an active employee spouse from using both contributions to the extent needed for purchase of one (1) state sponsored health insurance policy for that plan year."

Example: A hazardous-duty retiree receives a fully paid family plan from KRS. The spouse of the hazardous-duty retiree is an active employee. The spouse can elect to be covered either in the family plan or under a single plan through the active employer. If the active employee elects coverage under the hazardous-duty retiree's family plan, he/she will not be allowed to waive and receive an active employer contribution into an HRA.

KRS retirees that have returned to active employment have the option to select coverage either through KRS or through the active employer. Refer to Chapter 1, section I, B, Retirees, for additional information. For specific details contact KRS.

KTRS retirees that have returned to active employment must select coverage through the active employer. Refer to Chapter 1, section I, B, Retirees, for additional information. For specific details contact KTRS.

Retirees 65 and older who return to work

Retirees 65 and older who are receiving KRS or KTRS funds toward a Medicare Supplemental plan, are **NOT** eligible to receive state funding through the active employer for either a stand-alone HRA or an insurance plan. If they waive coverage through their active employer, they will not receive an HRA. In addition, if they select an insurance plan through their employer, they will not receive state funding toward the cost of the plan.

IV Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is legislation enacted by the federal government to: ensure health insurance portability; reduce health care fraud and abuse; guarantee the integrity and confidentiality of health information; and improve the operations of the health care system.

A. Privacy

HIPAA specifically addresses protecting the privacy of protected health information (PHI). The government has established limitations on the sharing of PHI.

PHI is medical and demographic information that is identifiable to a specific person. Examples of PHI are an individual's address, gender, Social Security Number, date of birth, diagnosis or claims history.

B. What is DEI doing to comply with HIPAA?

Due to the need to comply with HIPAA, the DEI implemented several changes designed to protect health information used in electronic mail. These changes are applicable to all programs.

When a plan member's information is being transmitted via electronic mail there are two competing interests: (1) The plan member has an expectation that the use of PHI is limited to the minimum necessary to carry out the purpose of the communication; and (2) The employees involved in the communication have an interest in sharing the maximum amount of information permissible to expediently carry out their job function.

In addition to those concerns, electronic mail is considered a public document and is subject to open records requests. One of the DEI's concerns is that PHI transmitted via electronic mail may be inadvertently disclosed to the public through an open records request.

Based on these concerns, the DEI implemented the following procedures for transmitting member information (PHI or personally identifiable information) to carriers and coordinators via electronic mail:

- Use encrypted email to transmit any PHI. If encryption is not available, the DEI has implemented a web based method by which information is transmitted in a secure environment. If you need to communicate a member's information to the DEI and your agency does not use any encryption or web based method, you may send emails by writing the word "Confidential" with the member's last name in the subject line (ex. Confidential – Smith).

  Using the word "Confidential" and the member's last name in the subject line ensures that the Commonwealth Office of Technology (COT) can identify all electronic mail to and from this office containing personally identifiable information. If an open records request is made that would

include any electronic mail marked *confidential,* the request will be forwarded to the DEI so that the requested electronic mail may be edited before complying.

- Use the member's last four (4) digits of the Social Security Number in the text of the electronic mail message to identify the member. Although the abbreviated information may cause some inefficiency in communication, it is necessary to protect the information of our members.

- Ensure that any attachments that contain PHI are password-protected.

- Include only the information necessary to resolve the issue and any additional relevant information.

- Members of the KEHP must complete and sign an Authorization for Disclosure Form to allow the DEI to disclose information pertaining to eligibility, enrollment, termination and QEs regarding a member's health plan and/or flexible spending accounts to the member's spouse or dependents. Information pertaining to payment of claims and benefits covered under the health plan must be directed to the TPA. The authorization forms can be found on the DEI's Web site. Members may also contact the DEI's Member Services Branch to request a copy of the form.

Members will need to contact their TPA for information relating to payment of claims and which benefits are covered under the member's health plan. If the member needs to have information disclosed from the TPA to someone other than themselves, the TPA may require the member to complete its agency's Authorization for Disclosure Form. The Authorization for Disclosure Form completed for the DEI to disclose PHI will not be accepted by the TPA. The member will be required to abide by the TPA's policies and procedures concerning release of the member's PHI.

V Health Insurance/Prescription I.D. Cards

- Employees will receive their I. D. card(s) within fourteen (14) days of receipt of enrollment information by the TPA.
- Employees that have not received their I.D. card and need proof of coverage may go to Humana.com and follow these steps:
  - Click on the section called *Members;*
  - Go to *Quick Links* located at the bottom right hand corner;
  - Click on *View ID Card;*
  - Enter the requested information under *Commercial Group Health Members;*
  - Click on *View ID Card;*
  - Print the employee's temporary card.
- Even though the KEHP has two administrators (Humana for medical benefits and Express Scripts, Inc. for pharmacy benefits), members will only receive one I.D. card.
- For privacy reasons, the planholder's Social Security Number is not printed on the I.D. cards.
- Employees may request additional I.D. cards by calling 1-877-KYSPIRIT (1-877-597-7474).

QUALIFYING EVENTS

I Section 125 Cafeteria Plan

The Kentucky Employees Health Plan (KEHP) is provided through a Section 125 plan. This allows employees to pay for their health insurance premiums with pre-tax monies. Section 125 plans are federally regulated. Federal guidelines state that if employees' health insurance is offered through a Section 125 plan, they cannot make a change in their health insurance options outside of the Open Enrollment period unless they experience a permitted election change (the DEI refers to those permitted election changes as qualifying events (QE)). Permitted election changes are also governed by federal guidelines.

II Changes in Coverage during the Open Enrollment Period

All changes are permitted during Open Enrollment with the following exception:

- Employees cannot drop dependent children for whom they are required by an administrative order to provide coverage if enforcement of the order is directed to the employer.

III Qualifying Event Chart

This chart reflects the mid-year election changes permitted in health insurance for the entire group and the changes permitted in the Healthcare FSA, Dependent Care FSA and Health Reimbursement Account (waivers only).

This chart describes the election changes that a cafeteria plan can permit employees to make during a period of coverage under the cafeteria plan regulations, as amended. This chart reflects our views of permitted election changes, which are adopted for the Plan Year 2007 and each Plan Year thereafter unless amended. The only required mid-year election changes are those related to loss of eligibility (death, divorce, loss of dependency and age.)

Note: The *Health Reimbursement Account (waiver only)* column is intended for use by members who are currently enrolled in a waiver with an HRA and who experience a corresponding QE under the *Event* column. The waiver HRA column states what members are allowed to do with their stand-alone HRA if they experience that QE.

Updated April 2008

Permitted Election Changes

Event	Health Insurance Plan Covering Expenses of Employee, Spouse, Eligible Dependents	Health Care FSA Covering Expenses of Employee, Spouse, Dependents	Dependent Care FSA	Health Reimbursement Account (Waiver Only)
Change in Employee's Legal Marital Status				
Marriage (Gain Spouse)	Employee may add self and/or spouse and/or dependents (1) (11) (12) *or* --- Employee may drop self/dependents if person becomes covered under spouse's plan (10) (12)	Employee may enroll or increase election *or* --- Employee may decrease employee election if family members become covered under spouse's health plan (2)	Employee may enroll or increase election if marriage increases dependent care expenses (3) *or* --- Employee may terminate or decrease election if family elects dependent care assistance under spouse's plan or marriage decreases dependent care expenses (3)	Employee may terminate election and redirect the state contribution to health insurance.
Divorce, legal separation, annulment (Lose Spouse)	Employee may add self and dependents <u>if event causes loss of coverage under spouse's plan</u>, (1) (10) (11) (12) *or* --- Employee may drop spouse; also drop family members added to former spouse's plan (10) (12)	Employee may enroll or increase election if event causes loss of coverage under spouse's health plan (2) *or* --- Employee may decrease employee election	Employee may enroll or increase election if event increases dependent care expenses (3) or causes loss of coverage under spouse's plan *or* Employee may terminate or decrease election if event decreases dependent care expenses (3)	Employee may terminate election and redirect the state contribution to health insurance <u>if event causes loss of coverage under spouse's plan</u> (10)
Spouse's death	Employee may add self and any dependent who loses coverage under spouse's plan, (1) (10) (11) (12) *or* --- Employee may drop spouse (12)	Employee may enroll or increase election if death causes loss of coverage under spouse's health plan (2) *or* --- Employee may decrease employee election	Employee may enroll or increase election if death causes loss of coverage under spouse's plan or increases dependent care expenses (3) *or* --- Employee may terminate or decrease election if death decreases dependent care expenses (3)	Employee may terminate election and redirect the state contribution to health insurance <u>if event causes loss of coverage under spouse's plan</u> (10)
Change in Number of Employee's Dependents				

Number of employee's eligible dependents increases by the following: **birth;** **adoption (10); and** **placement for adoption (10)**	Employee may add self and/or spouse and/or other dependents (1) (11) (12)	Employee may enroll or increase election	Employee may enroll or increase election if employee has greater dependent care expenses	Employee may terminate election and redirect the state contribution to health insurance.
Number of employee's eligible dependents decreases (e.g., by death or because child becomes ineligible)	Employee may drop affected dependent (12)	Employee may decrease employee election	Employee may terminate or decrease election if employee has reduced dependent care expenses	Does not apply No change allowed
Change in Employee's Employment Status				
Employee terminates employment	Cease employee and employer contributions; COBRA rules may apply	Cease employee contributions; COBRA rules may apply	Cease employee contributions; COBRA rules do not apply	Cease employer contributions; COBRA rules may apply
Employee is rehired less than 30-days after termination of employment.	Employee may reinstate prior election unless another event has occurred that allows a change (9)	Employee may reinstate prior election unless another event has occurred that allows a change (9) If employee did not elect COBRA during termination period, reinstatement of the prior coverage can be accomplished with one of the following methods (employee's choice): *Proration:* Employee may elect to continue at the same monthly contribution as prior to the termination and the annual amount is reduced by the contributions missed during that period *or* *Reinstatement:* Employee may elect to makeup the shortfall resulting from the contributions missed during the terminated period	Employee may reinstate prior election unless another event has occurred that allows a change (9)	Employee may reinstate prior election unless another event has occurred that allows a change (9)
Employee is rehired 30 days	Employee may make election to same extent	Employee may make election to same extent	Employee may make election to same extent	Employee may make election to same

or more after termination of employment	permitted as new employee	permitted as new employee	permitted as new employee	extent permitted as new employee
Employee commences official leave without pay	Coverage/contributions cease in accordance with Plan rules; COBRA rules may apply	Employee contributions cease in accordance with Plan rules; COBRA rules may apply	Employee contributions cease; COBRA rules do not apply	Employer contributions cease in accordance with Plan rules; COBRA rules may apply
Employee returns from official leave without pay	Employee may reinstate prior election unless another event has occurred that allows a change (9)	Reinstate prior election unless another event has occurred that allows a change (9) Reinstatement of the prior coverage can be accomplished with one of the following methods (employee's choice): *(1) Proration:* Employee may elect to continue at the same monthly contribution as prior to the termination and the annual amount is reduced by the contributions missed during that period *or* *(2) Reinstatement:* Employee may elect to makeup the shortfall resulting from the contributions missed during the terminated period	Reinstate prior election. Employee may continue to file dependent care claims for the remaining funds in account until the end of the plan year, in accordance with IRS rules *or* Change election if event changes dependent care expenses (3)	Reinstate prior election unless another event has occurred that allows a change (9)
Employee begins unpaid FMLA (4)	Elections continue for up to 12 weeks or until employment terminates or until employee begins official leave without pay, whichever comes first. Employees must select one of the following options: Employee may terminate elections *or* Continue elections and make payments as follows: (1) Prepayment: Increase deductions to prepay coverage contributions for FMLA period *or* (2) Pay-as-you-go: Employee may make contributions on the same schedule as payments would have	Elections continue for up to 12 weeks or until employment terminates or until employee begins official leave without pay, whichever comes first. Employees must select one of the following options: Employee may terminate elections *or* Continue elections and make payments as follows: (1) Prepayment: Increase contribution to prepay coverage during leave *or* (2) Pay-as-you-go: Employee may make contributions on the same schedule as payments would have	Decrease election if leave causes a decrease in dependent care expenses (3) *or* Employee may terminate elections *or* Continue elections and make payments as follows: (1) Prepayment: Increase contribution to prepay coverage during leave *or* (2) Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made	Elections continue for up to 12 weeks or until employment terminates or until employee begins official leave without pay, whichever comes first.

	been made otherwise *or* (3) Catch-Up Option: If agreed to by both parties PRIOR to the FMLA leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment	been made otherwise *or* (3) Catch-Up Option: If agreed to by both parties PRIOR to the FMLA leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment	otherwise *or* (3) Catch-Up Option: If agreed to by both parties PRIOR to the FMLA leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment	
Employee returns from unpaid FMLA	Employee may continue elections. If elections ceased during FMLA, employee may reinstate prior elections unless another event has occurred that allows a change (9)	Employee may continue contributions. If contributions ceased during FMLA, employee must be able to reinstate prior elections and may choose one of the following: (1) Proration: Employee may elect to continue at the same monthly contribution as prior to the FMLA and the annual amount is reduced by the contributions missed during the FMLA *or* (2) Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during FMLA.	Generally same rights as employee returning from non-FMLA leave, though employee must be able to reinstate prior coverage	Continue contributions
Employee begins unpaid Military Leave	Employee may cease elections *or* Employee may continue elections and make payments as follows: (1) Prepayment: Increase contribution to prepay coverage during leave *or* (2) Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise *or*	Employee may cease employee contributions *or* Continue elections and make payments as follows: (1) Prepayment: Increase contribution to prepay coverage during leave *or* (2) Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise *or*	Employee may cease employee contributions *or* Continue elections and make payments as follows: (1) Prepayment: Increase contribution to prepay coverage during leave *or* (2) Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been made otherwise *or*	Cease contributions

	(3) Catch-Up Option: If agreed to by both parties PRIOR to the leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment	(3) Catch-Up Option: If agreed to by both parties PRIOR to the leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment	(3) Catch-Up Option: If agreed to by both parties PRIOR to the leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment	
Employee returns from unpaid Military Leave ***** Employees returning from Military Leave are eligible for coverage immediately upon return or may delay the effective date until military coverage ends.	Employee may reinstate prior election unless another event has occurred that allows a change (9)*	Employee must be able to reinstate prior coverage and can choose one of the following: (1) Proration: Employee may elect to continue at the same monthly contribution as prior to the leave and the annual amount is reduced by the contributions missed during the leave *or* (2) Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during leave	Generally same rights as employee returning from non-FMLA leave, though employee must be able to reinstate prior coverage	Employee may reinstate contributions or reinstate prior election unless another event has occurred that allows a change (9)
Employee commences paid leave (assuming event does not affect eligibility for coverage)	No change allowed	No change allowed	Employee may decrease election if event decreases dependent care expenses (3)	Does not apply No change allowed
Employee returns from paid leave	No change allowed	No change allowed	Employee may increase election if event increases dependent care expenses (3)	Does not apply No change allowed
Employee changes worksite	No change allowed	No change allowed	Employee may decrease election if event decreases dependent care expenses (3) (10) *or* Employee may increase election if event increases dependent care expenses (3) (10) (unless the care provider is a relative)	Does not apply No change allowed

Other change in employee's employment status (e.g., switch from salaried to hourly status) that causes employee to cease eligibility under plan	Coverage/contributions cease in accordance with Plan rules; COBRA rules may apply	Coverage/contributions cease in accordance with Plan rules; COBRA rules may apply	Employee contributions cease; COBRA rules do not apply	Employer contributions cease; COBRA rules may apply
Other change in employee's employment status (e.g., switch from hourly to salaried status) that causes employee to become eligible for coverage under plan	Employee may make elections as if a new employee, unless there was less than a 30-day break in eligibility	Employee may make elections as if a new employee, unless there was less than 30-day break in eligibility	Employee may make elections as if a new employee, unless there was less than 30-day break in eligibility	Employee may make elections as if a new employee, unless there was less than a 30-day break in eligibility
Change in Spouse or Dependent Employment Status (Dependent must continue to meet all eligibility requirements.)				
Spouse or dependent terminates employment (or other change in employment status resulting in a loss of eligibility under the spouse or dependent's plan)	Employee may add self, spouse, and dependents (1) if event adversely affects eligibility for coverage under spouse's or dependent's health plan (10) (11) (12)	Employee may enroll or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Employee may start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan *or* Employee may terminate or decrease election if event decreases dependent care expenses (3)	Employee may stop election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan (10)
Spouse or dependent commences employment (or other change in employment status triggering eligibility under the spouse or dependent's plan)	Employee may drop self, spouse, or dependent who becomes covered under spouse's or dependent's plan (12) (10)	Employee may decrease or cease election if family becomes covered under health plan of spouse or dependent (2)	Employee may start or increase election if event increases dependent care expenses (3) *or* Employee may terminate or decrease election if family becomes covered under spouse's dependent care assistance plan	Does not apply No change allowed
Spouse or dependent is out of work due to strike or lockout	Employee may add self, spouse, and dependents (1) if event adversely affects eligibility for coverage under health plan of spouse or dependent (10) (11) (12)	Employee may start or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Employee may start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan *or* Stop or decrease election if event decreases dependent care expenses (3)	Employee may stop election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan (10)

Spouse or dependent returns to work following cessation of strike or lockout	Employee may drop self, spouse, or dependent who becomes covered under spouse's or dependent's health plan (12) (10)	Employee may decrease election if family becomes covered under health plan of spouse or dependent (2)	Employee may start or increase election if event increases dependent care expenses (3) *or* Stop or decrease election if family becomes covered under spouse's dependent care assistance plan	Does not apply No change allowed
Spouse or dependent commences unpaid leave (if the event adversely affects eligibility for coverage under the spouse or dependent's plan)	Employee may add self, spouse, and dependent (1) (10) (11) (12)	Employee may enroll or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2)	Employee may enroll or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan *or* Employee may terminate or decrease election if event decreases dependent care expenses (3)	Employee may terminate election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan (10)
Spouse or dependent returns from unpaid leave	Employee may drop self, spouse, or dependent who becomes covered under spouse's or dependent's health plan (12) (10)	Employee may decrease election if family becomes covered under spouse's or dependent's health plan (2)	Employee may start or increase election if event increases dependent care expenses (3) *or* Employee may terminate or decrease election if family becomes covered under spouse's dependent care assistance plan	Does not apply No change allowed
Other change in spouse's or dependent's employment status that causes spouse or dependent to cease to be eligible for coverage under spouse's or dependent's plan (e.g., switch from salaried to hourly status)	Employee may add self, spouse, and dependent (1) (10) (11) (12)	Employee may enroll or increase election (2)	Employee may enroll or increase election if event adversely affects eligibility for coverage under spouse's plan (3)	Employee may terminate election and redirect the state contribution to health insurance if event causes loss of coverage under spouse's plan (10)
Other change in employment status that causes spouse or dependent to gain eligibility for coverage under spouse's or dependent's plan (e.g., switch from	Employee may drop coverage for self, spouse, or dependent who becomes covered under spouse's or dependent's plan (10) (12)	Employee may decrease election if family members become covered under health plan of spouse or dependent (2)	Employee may decrease election *or* Employee may increase election if event increases dependent care expenses (3)	Does not apply No change allowed

hourly to salaried status)				
Change in Dependent Eligibility				
Dependent ceases to satisfy plan eligibility requirements on account of age, marriage or any similar circumstance (support and maintenance)	Employee may drop coverage for dependent (12)	Employee may decrease election	Employee may terminate or decrease election if event decreases dependent care expenses (3) (10)	Does not apply No change allowed
Unmarried dependent re-establishes plan eligibility requirement under applicable plan	Employee may add dependent who satisfies plan eligibility requirement (5) (12)	Employee may enroll or increase election (5)	Employee may enroll or increase election if event increases dependent care expenses (3) (10)	Does not apply No change allowed
Change in Residence				
Employee or spouse changes primary (6) residence and becomes ineligible for current benefit election	No change allowed	No change allowed	Employee may make a corresponding election change if the child care provider changes (10)	Does not apply No change allowed
Other Events				
Loss of other group health insurance coverage or health insurance coverage that entitles employee or family member to be enrolled under HIPAA Special Enrollment Rights	Employee may add self (1) (10) (11) (12) *or* --- Employee may add spouse and/or dependent (1) (10) (11) (12)	Employee may enroll or increase election *or* --- Employee may enroll or increase election	No change allowed	Employee may terminate election and redirect the state contribution to health insurance (10)
Judgment, decree, or administrative order relating to health coverage for child	Employee may add child if required under order (10) (11) (12) *or* --- Employee may drop child if other parent provides coverage under order (10) (12)	Employee may enroll or increase election if order requires employee to provide child's health coverage *or* --- Employee may decrease election if other parent covers child under order	No change allowed	Employee may terminate employer contribution

Employee, spouse, or dependent enrolled in employer's health plan becomes entitled to Medicare (Part A or Part B) or Medicaid	Employee may make an election change that corresponds to the event (10) (12)	Employee may decrease election	No change allowed	Does not apply No change allowed
Employee, spouse, or dependent loses entitlement to Medicare (Part A or Part B), Medicaid, KCHIP, any governmental group health insurance coverage	Employee may enroll self, spouse, or dependent (1) (10) (11) (12)	Employee may enroll or increase election	No change allowed	Employee may terminate election and redirect the state contribution to health insurance (10)
Cost or Coverage Changes (8)				
Change in Cost				
Benefit option has significant increase or decrease in cost	Does not apply No change allowed	Does not apply No change allowed	Employee may make a corresponding change (increase or decrease). Increasing the election for a day care provider raising rates mid-year is only permitted if the provider is not a relative of the employee	Does not apply No change allowed
Change In Coverage Under Another Employer Plan				
Employee's spouse makes elections during an open enrollment period that differs from the open enrollment period of the employer (7)	Employee may make election change that "corresponds" with spouse's election change (10)	*After Open Enrollment and before January 1:* Employee may make corresponding change *After 12/31* – No change allowed	Employee may make election change that "corresponds" with election change under the other employer plan	*After Open Enrollment and before January 1:* Employee may make corresponding changes and redirection of state contributions is allowed (10) *After 12/31:* Employee may make corresponding changes (10)
Employee makes elections during an open enrollment period of another employer that differs from the open enrollment period of the employer (7)	Employee may make election change that corresponds with the change made with the other employer's plan (10)	*After Open Enrollment and before January 1:* Employee may make corresponding change *After 12/31* – No change allowed	Employee may make election change that "corresponds" with the change made with the other employer's plan	*After Open Enrollment and before January 1:* Employee may make corresponding changes and redirection of state contributions is allowed (10) *After 12/31:* Employee may make corresponding changes (10)

Retiree makes elections during an open enrollment period of a state sponsored retirement system that differs from the open enrollment period of the employer	Retiree may make an election change that corresponds with the elections made with the retirement system plan (10)	No change allowed	No change allowed	Does not apply No change allowed
Individual changes election for any other event that is permitted under regulation (and terms of the employer plan)	Employee may make election change that "corresponds" with the event (10)	No change allowed	Employee may make election change that corresponds with the event	Does not apply No change allowed

End Notes:

(1) The final regulation preamble indicates that dependents that can be added are those who were directly affected by the status change event plus other dependents (the so-called "tag-along" rule). However, the examples in the regulation only explicitly deal with situations where an employee elects family coverage and adds family members at no additional cost. It is not clear, but IRS staff members have informally stated that the "tag-along" rule applies even if the employee must increase an election to add additional dependents. Also, the preamble and examples in the regulation indicate that the "tag-along" rule applies to HIPAA events and situations where a spouse terminates employment; it is not clear what other events might be covered by the "tag-along" rule.

(2) It appears this rule does not require that a spouse's coverage include a Health FSA.

(3) By an increase or decrease in dependent care expenses, we mean that the event increases or decreases the amount of expenses that an employee can have reimbursed on a tax-free basis under Code section 129 from a dependent care assistance plan. For example, if the employee gets married and his or her spouse does not work outside the home, the spouse would be available to care for a child, and thus the employee may not be able to claim that dependent care expenses are being used to enable the employee to be gainfully employed — a condition that must be satisfied for the expense to be reimbursed on a tax-free basis under Code section 129. Conversely, the marriage can increase the amount of expenses reimbursable under the dependent care assistance plan if, for example, a new spouse or stepchild is a "qualifying individual" for whom dependent care assistance can be received. A spouse's death or divorce might lead to fewer dependent care expenses eligible for reimbursement under section 129 if, for example, the spouse was a "qualifying individual." Conversely, if the spouse was not employed outside the home, the death or divorce might require the employee to pay for a caregiver in order to remain gainfully employed, and therefore the expenses may be reimbursed on a tax-free basis under section 129.

(4) Most employees are entitled to certain rights under the Family and Medical Leave Act (FMLA), whether or not the benefits are provided through a cafeteria plan. Employees generally must receive up to 12 weeks of unpaid FMLA leave, although the employee or employer generally can choose to substitute available paid leave for unpaid leave. During FMLA leave, the employer must maintain group health coverage (including FSA coverage) on the same conditions as coverage would be provided if the employee had not taken the leave. An employee's entitlement to other benefits during FMLA leave is determined by the employer's established policy for providing such benefits when the employee is on other forms of paid or unpaid leave (as appropriate). If benefits are continued during unpaid leave, proposed IRS regulations allow benefits purchased through a cafeteria plan to be paid in several ways,

including increased salary reductions before the leave to prepay benefits or using salary reductions after the leave to "catch-up" on payments. Benefits continued on paid FMLA leave are paid for in the same manner as during any paid leave. Employees can choose to drop benefits while on leave, but FMLA requires they have the right to be reinstated upon return from leave.

(5) For purposes of eligibility in this plan, a divorced dependent is not an "unmarried" dependent.

(6) Primary residence is the official residence claimed for tax purposes.

(7) Military Insurance Coverage, which does not include Veteran's Administration benefits, is considered "Another Employer Plan".

(8) "Cost or Coverage Changes under the Employer's Plan" are not included in this chart. In the event there is a mid-year change in the health plan, specific direction will be provided to the group or groups affected.

(9) An employee must request the mid-year election change within thirty (30) calendar days of the return to work date.

(10) Supporting documentation required.

(11) HIPAA Special Enrollment Right

(12) Qualifying Event permits change in plan option (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Select or Commonwealth Premier).

Effective Dates

Effective dates for the various mid-year election changes are as follows:

Health Insurance

A. Events increasing coverage
1. Birth, adoption, placement for adoption = Date of the event.
2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1st day of the 1st month from the employee's signature date.
3. Different Open Enrollment = 1st day of the 1st month (match effective date of other employer's plan).

B. Events decreasing coverage
1. Termination of employment = Last day of the month following the month in which employment ends.
2. Death = Date of death.
   a) Death of the employee with dependents = End of month in which death occurred.
   b) Death of employee no dependents = Date of death.
   c) Death of dependent = Date of death.
3. Divorce, loss of dependent status = End of the month of loss of eligibility.
4. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.
5. Different Open Enrollment = Last day of the month (match other employer's plan).

Healthcare Flexible Spending Account (HC FSA)

A. Events starting or increasing HC FSA contributions
1. Birth, adoption, placement for adoption = 1st day of the 1st month from the employee's signature date.

2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1st day of 1st month from the employee signature date.
3. Different open enrollment = 1st day of the 1st month (match effective date of other employer's plan).
4. Return from Leave Without Pay = 1st day of the 1st month from the employee's signature date.
5. Return from Military Leave = Date of return to work.

B. Events stopping or decreasing HC FSA contributions

1. Termination of employment = Date of termination of employment.
2. Death = Date of death.
3. Divorce, loss of dependent status = End of the month of loss of eligibility.
4. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.
5. Different open enrollment = Last day of the month (match other employer's plan).
6. Begins Leave Without Pay or Military Leave = Last date of work.

Dependent Care Flexible Spending Account (DC FSA)

A. Events starting or increasing DC FSA contributions

1. Dependent is newly eligible to begin attending day care = 1st day of 1st month from the employee's signature date.
2. Change in dependent's eligibility status = 1st day of 1st month from the employee's signature date.

B. Events stopping or decreasing DC FSA contributions

1. Termination of employment = Date of termination of employment.
2. Dependent no longer attends day care = End of the month from the employee's signature date.
3. Change in dependent's eligibility status = End of the month from the employee's signature date.
4. Death = Date of death.

Health Reimbursement Account (HRA)

A. Events allowing enrollment in a Health Plan

1. Birth, Adoption, placement for adoption = Date of the event.
2. Marriage, loss of other coverage, court or administrative orders for dependent(s), expiration of COBRA = 1st day of the 1st month from the employee signature date.
3. Different open enrollment = 1st day of the 1st month (match effective date of other employer's plan).
4. Returning from Military Leave = Date of return to work or day after TRICARE ends (employee's option).

B. Events allowing contributions to cease (for reasons other than enrolling in the plan).

1. Termination of employment = Date of termination of employment.
2. Death = Date of death.
3. Different open enrollment = Last day of the month (match other employer's plan).
4. Start Military Leave = Date of the event.

All Qualifying Events must be signed by the employee thirty (30) calendar days from the date of the Qualifying Event, except for birth, adoption, or placement for adoption when adding the newly acquired dependent only, which is sixty (60) days. Qualifying Events dealing with loss of other group coverage or gaining other group coverage may be signed by the employee prior to the Qualifying Event date. In any case, a requested change due to a Qualifying Event will not be effective prior to the event taking place.

IV Supporting Documentation

The DEI reserves the right to ask for documentation for any QE and for additional supporting documentation, if needed.

If supporting documents are required, but not immediately available, your employees must NOT delay signing and dating the required form or application. The form/application may be submitted to DEI and will be pended for documentation for a period of sixty (60) days awaiting the required documentation.

- Divorce/Legal Separation/Annulment (if dropping members from policy):
  - Divorce decree signed by a judge and date-stamped "filed" or "entered"; or
  - Legal separation papers signed by a judge and date-stamped "filed" or "entered"; or
  - Annulment papers signed by a judge and date-stamped "filed" or "entered".

- Adoption/Placement for adoption:
  - Placement papers from the Cabinet for Health and Family Services; or
  - Signed and date-stamped "filed" papers from the court; or
  - Letter from adoption agency on letterhead; or
  - Legal document from a US court; or
  - Official document translated into English and/or copy of the child's visa – if foreign adoption.

- Judgment, decree or administrative order relating to health coverage for the child (*adding a grandchild requires guardianship or custody papers*; adding a foster child requires placement papers from the Cabinet for Health and Family Services or a filed and dated court decree):
  - Filed and dated court decree; or
  - Agency administrative order; or
  - National Medical Support Notice.

- Employee, spouse or dependent enrolled in employer's health plan becomes entitled to Medicare:
  - Copy of Medicare card; or
  - Initial eligibility letter from the Medicare office.

- Employee, spouse or dependent enrolled in employer's health plan becomes entitled to Medicaid:
  - Initial eligibility letter from the Medicaid office.

- Loss of other health insurance coverage that entitles employee or dependent to be enrolled under HIPAA:
  - HIPAA certificate from prior carrier; or
  - Letter from employer/previous employer, on letterhead, identifying the coverage termination date and the person(s) covered under the policy; or
  - Letter from insurance agency identifying the type of coverage, the reason for termination and the person(s) covered under the policy; or

- Termination letter from governmental agency under which previous coverage was held.

- Gaining other group health insurance coverage:
  - Letter from employer, on employer's letterhead, identifying the coverage begin date and the person(s) covered by the policy; or
  - Copy of new health insurance I.D. card(s) for each covered person, stating the coverage begin date.

- Different Open Enrollment:
  - Letter from employer, on employer's letterhead, identifying open enrollment deadline, effective date, and persons who are being added to or dropped from the policy.

V General Guidelines Regarding Qualifying Events

After the Open Enrollment period, employees must experience a QE (as listed in the Qualifying Event Chart) to add or drop dependents or, under appropriate circumstances, make other permitted changes. Unless otherwise indicated in the following explanations, if there is a discrepancy between the Detailed Description of Permitted Qualifying Events below and the Qualifying Event Chart as described in the Summary Plan Description (SPD), the information in the SPD prevails. You may find the SPDs posted on the Personnel Cabinet, Department for Employee Insurance Web site at www.kehp.ky.gov.

- Most QEs have a signature deadline of thirty (30) calendar days from the event date. However, some have a signature deadline of sixty (60) calendar days from the event date. It is important to know the signature deadlines for all QEs. Most effective dates are the first day of the month following the signature date. For purposes of determining the thirty (30) or sixty (60) calendar day deadline for QEs, the GHI system counts thirty (30) or sixty (60) calendar days beginning on the day after the QE.

- A request for a change, due to QEs, cannot be signed before the event takes place; except for the following:
  - Loss of other health coverage;
  - Gaining other group coverage;
  - Entitlement to Medicare; and
  - Spouse's different open enrollment period.

- In any case, a requested change due to a QE will not be effective prior to the event taking place. To apply this rule, consider the following:

  - If the QE date is the first of the month, the employees may pre-sign during the previous month. For example, if loss of coverage occurs on April 1, the employees may sign the application or Dependent Add Form during the month of March. The effective date of the change will be April 1.
  - If the QE date is any other day of the month, the employees may pre-sign during that month only. For example, if loss of coverage occurs on April 18, the employees may sign the application or Dependent Add Form during the month of April. The effective date of the change will be May 1.

- The QE date is the date the event takes place and not the date the employees or dependents are notified of the event. The DEI will accept notification date only for Entitlement to CHAMPVA, TRICARE, and governmental programs such as Medicare and Medicaid. Gaining KCHIP is not a permitted QE.

- Forms to use:
  - Members will complete an Enrollment Application if they are electing new coverage, waiving and enrolling in a new stand-alone HRA, selecting a new payment option, or requesting an option change based on experiencing a QE.
  - Members will complete a Dependent Drop Form if they are electing to drop dependents due to experiencing a QE.
  - Members will complete a Dependent Add Form if they are electing to add dependents due to experiencing a QE.
  - Insurance Coordinators will complete a Health Insurance Update Form to report an employee's demographic changes, terminations, leaves of absence, reinstatements, etc. Terminations and demographic changes may be made using the web enrollment system. (See Chapter 8 for changes that may be made online.)
  - Insurance Coordinators will include a Transmittal Log with all forms submitted to the Enrollment Information Branch in order to receive confirmation that the forms have been received.
  - All forms are available on the web at www.kehp.ky.gov. Look under the Insurance Coordinator section.

- The smoking status may only be updated during the Open Enrollment period, for a break in service of 30 days or more (new employee), or as a new retiree. It may **not** be changed due to:

  - Member experiencing a QE;
  - Member experiencing a break in service (employment) of 0-29 days;
  - Member quitting smoking during the Plan Year.

VI Detailed Description of Permitted Qualifying Events

A. Change in legal marital status

1. Marriage

- **What can employees do?**

  - Add themselves and/or their spouse and/or their eligible dependent children;
  - Add tag-alongs;
  - Drop themselves (by completing an Enrollment Application to waive) **if they become covered under the spouse's group plan**; or
  - Drop their dependent children **if they become covered under the spouse's group plan**.
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier, and

Commonwealth Select).
- If the employee is a stand-alone waiver with an HRA, stop election and redirect the state contribution to health insurance.

  Note: Marriage does not allow employees to enroll themselves **only**.

- **Effective date**

  - If adding – first day of the month following the employee's signature on the application or Dependent Add Form.
  - If dropping – end of the month of the employee's signature on the application or Dependent Drop Form.

- **Deadline**

  Thirty (30) calendar days from the event date.

  Note: The event date when adding dependents is the date of marriage. The event date to drop dependents is the date the dropped members gain other group health insurance coverage under the spouse's plan.

- **Supporting documentation needed**

  - If adding – none;
  - If dropping due to gaining other group health coverage – see *Supporting Documentation* in section IV.

2. Divorce, legal separation, annulment

- **What can employees do?**

  - Drop dependent children if they cease to meet the eligibility requirements under the KEHP – ineligible dependents MUST be dropped;
  - Drop former spouse only – the ineligible spouse MUST be dropped from the plan;
  - Drop dependent children <u>if they are added to former spouse's group plan; or</u>
  - Add themselves and/or their dependent children <u>if the event causes loss of coverage under the former spouse's plan;</u> including tag-alongs;
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier, and Commonwealth Select).
  - If employee is a waiver, stop election and redirect the state contribution to health insurance <u>if event causes a loss of coverage under the spouse's plan</u>.

- **Effective date**

  - If adding – first day of the month following the employee's signature on the application or Dependent Add Form;
  - If dropping former spouse– end of the month of the divorce, legal separation or annulment;
  - If dropping dependent children that were added to former spouse's group plan – end of the month of the employee's signature on the Dependent Drop Form.

- **Deadline**

  Thirty (30) calendar days from the event date. This QE makes the former spouse ineligible to participate in the KEHP; therefore, the former spouse must be dropped from the plan at the end of the month of ineligibility, even if the thirty (30) day deadline is not met.

  Note: When enrolling themselves or adding dependents, the event date is the date of loss of coverage.

- **Supporting documentation needed**

  - If adding themselves and their dependent children if the event causes loss of other coverage - see *Supporting Documentation* in Section IV, under loss of other coverage;
  - If dropping - see *Supporting Documentation* in section IV, under divorce/legal separation/annulment.

3. Spouse's death

- **What can employees do?**

  - Add themselves and their dependent children that have lost coverage under the spouse's plan, including tag-alongs;
  - Drop spouse from plan;
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier, and Commonwealth Select).
  - If employee is a waiver and is enrolled in the Health Reimbursement Account, stop election and redirect the state contribution to health insurance if event causes a loss of coverage under the spouse's plan.

- **Effective date**

  - If adding – first day of the month following the employee's signature on the application or Dependent Add Form;
  - The spouse's coverage will end on the spouse's date of death. The new plan will be effective on the day following the date of death.

- **Deadline**

  - If adding - thirty (30) calendar days from the date of loss of other coverage;
  - If dropping - upon notification of the spouse's death. The deceased spouse's coverage will be terminated even if the thirty (30) day deadline is not met.

- **Supporting documentation needed**

  - To add themselves and their dependent children if the event causes loss of other coverage - see *Supporting Documentation* in section IV, under loss of other coverage;
  - To drop the deceased spouse – none.

- **Other**

  Employees that experience this QE may be eligible for a premium refund.

  - If the event date is between the 1st and the 15th of a month, the employee will be entitled to any refund for the month of death resulting from a plan level change (family to parent plus or couple to single).
  - If the event date is between the 16th and the end of a month, the employee will not be entitled to any refund resulting from a plan level change (family to parent plus or couple to single) due to the spouse's death.

B Change in number of dependents

1. Birth/adoption/placement for adoption

- **What can employees do?**

  - If employee is a waiver, stop election and redirect the state contribution to health insurance;
  - Add themselves and/or their newborn child(ren), adopted child(ren) or placed child(ren), including tag-alongs;
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier, and Commonwealth Select).

  NOTE: To add grandchildren, members must use the QE *judgment, decree or administrative order relating to health coverage for the child*.

- **Effective date**

  - For birth - the child's date of birth;
  - For adoption – the child's adoption date;

- For placement (including placement by judgment and court orders)- the child's placement date;

  Note: The effective date of any changes to a Flexible Spending Account, due to this Qualifying Event, is the first day of the month following the employee's signature date on the application or Dependent Add Form.

- **Deadline**

  - Sixty (60) calendar days from the child's date of birth, the child's adoption date or the child's placement date when adding the newly acquired child(ren) ONLY;
  - Thirty (30) calendar days from the child's date of birth, the child's adoption date or the child's placement date when adding the newly acquired child **PLUS** any other dependents (tag-alongs).

- **Supporting documentation needed**

  - For birth – none;
  - For adoption or placement for adoption – see *Supporting Documentation* in section IV, under adoption/placement for adoption.

- **Other**

  Employees that experience this QE and whose coverage level will change due to the event (single to parent plus or couple to family), will submit premium payments as follows:

  - If the child is born, adopted or placed between the 1st and the 15th of the month, the employee will be responsible for payment of premiums for the entire month at the new coverage level.
  - If the child is born, adopted or placed between the 16th and the end of the month, the employee will not be responsible for payment of premiums for the month of birth, adoption or placement at the new coverage level.

2. Death of a dependent child or dependent child becomes ineligible (ceases to meet the eligibility requirements under the KEHP)

- **What can employees do?**

  - End coverage for the deceased dependent;
  - drop the ineligible dependent – ineligible dependents MUST Be dropped from the plan;
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier, and Commonwealth Select).

- **Effective date**

  - Coverage of the deceased dependent will end on the dependent's date of death;
  - If the dependent's death causes a plan level change (parent plus to single or family to couple), the new plan will be effective on the day following the dependent's date of death;
  - The ineligible dependent's coverage will end at the end of the month in which the dependent becomes ineligible (due to the dependent's marriage, change in primary residence, etc.);
  - If the dependent became ineligible due to attaining the limiting age, the ineligible dependent's coverage will end at the end of the year in which the dependent turns 23;
  - Coverage for disabled dependents that are enrolled in the Plan prior to attaining the limiting age may continue without age limitations. Refer to Chapter 1, section I, under ***Eligible Participants,*** for more information.

- **Deadline**

  - Thirty (30) calendar days from the dependent's date of death or from the dependent's ineligibility date;
  - Upon notification of the dependent's death or ineligibility date, the dependent termination will be processed even if the thirty (30) calendar day deadline is not met.

- **Supporting documentation needed**

  - For a deceased dependent – none;
  - For an ineligible dependent – none, in most cases; however, the DEI reserves the right to request supporting documentation. The Insurance Coordinator will be notified if supporting documentation is needed.

- **Other**

  Employees that experience the QE of death of a dependent may be eligible for a premium refund, as follows:

  - If the event date is between the 1st and the 15th of a month, the employee will be entitled to any refund for the month of death resulting from a plan level change (parent plus to single or family to couple).
  - If the event date is between the 16th and the end of a month, the employee will not be entitled to any refund resulting from a plan level change (parent plus to single or family to couple) due to the dependent's death.

  Employees that experience the QE of dependent child becomes ineligible will be entitled to a refund as determined in the

Retroactivity Related to Premium section.

C. Change in employee's employment status

1. **Employees terminate employment –** see *Terminations* in Chapter 1.

2. **Employees are rehired less than 30 days after termination of employment –** see *Transfers and Rehires* in Chapter 1.

3. **Employees are rehired 30 days or more after termination of employment –** see *Transfers and Rehires* in Chapter 1.

4. **Employees commence official leave without pay (LWOP) –** see *Leave Without Pay (LWOP)* in Chapter 6.

5. **Employees return from official leave without pay (LWOP) –** see *Leave Without Pay (LWOP)* in Chapter 6.

6. **Employees commence FMLA leave –** see *Family Medical Leave Act (FMLA)* in Chapter 6.

7. **Employees return from FMLA leave –** see *Family Medical Leave Act (FMLA)* in Chapter 6.

8. **Employees commence military leave –** see *Military Leave* in Chapter 6.

9. **Employees return from military leave –** see *Military Leave* in Chapter 6.

10. **Employees commence paid leave –** see *Paid Leave* in Chapter 6.

11. **Employees return from paid leave –** see *Paid Leave* in Chapter 6.

12. **Employee changes worksite –** changes are permitted only to the employee's Dependent Care FSA.

13. **Other changes in employee employment status that cause employee to cease eligibility**

    - Cease contributions;
    - Insurance Coordinator completes a Health Insurance Update Form to report the employee termination date and the date coverage terminates.

14. **Other changes in employee employment status that cause employee to become eligible for coverage under the plan**

    - Make elections as if a new employee, unless there was less than a 30 (thirty) day break in employment, in which case changes are not allowed;
    - If the break in service is 30 (thirty) days or greater, the employee must complete an application following the new employee guidelines as described in Chapter 1,

section V, *Initial Enrollment*.

D. Change in spouse or dependent employment status

1. Spouse or dependent loses other employer-sponsored health coverage (termination of employment, strike or lockout, commencement of unpaid leave, loss of eligibility under the employer's plan, etc.)

Note that some employers may offer a few months of COBRA payments to terminated employees as part of a severance package. It is important to remind your employees that the end of the employer-paid COBRA coverage is NOT a QE that would allow enrollment in the KEHP as the COBRA continuation coverage period has not been exhausted. ***Only Expiration of COBRA is considered loss of other coverage.***

- **What can employees do?**
  - Add themselves, spouse and dependents if the event adversely affects eligibility for coverage under spouse's health plan (loss of employer-sponsored group health coverage);
  - Add the dependent that loses eligibility under the dependent employer (other than spouse) if they meet all eligibility requirements under the KEHP;
  - Add tag-alongs;
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, and Commonwealth Premier).

- **Effective date**
  - First day of the month following the employee's signature date on the application or Dependent Add Form;
  - The requested change will not be effective prior to the QE date.
  - Commonwealth Enhanced, Commonwealth Premier).

- **Deadline**
  - Thirty (30) days from the QE date. The QE date is the date the added members lose coverage under the employer-sponsored group health plan;
  - The application or Dependent Add Form may be signed by the employee prior to the loss of coverage.
  - Commonwealth Enhanced, Commonwealth Premier).

- **Supporting documentation needed**

  See *Supporting Documentation* in this Section, under loss of other coverage.

2. Spouse or dependent gains other employer-sponsored group health

coverage (by commencing employment, returning to work after a strike or lockout, returning from unpaid leave, gaining eligibility under the employer's plan, etc.)

- **What can employees do?**

  - Drop coverage for themselves, their spouse and dependents if they become covered under the employer-sponsored group health coverage (coverage gained must be employer-sponsored group coverage);
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, and Commonwealth Premier).

- **Effective date**

  - Last day of the month in which the employee signs the Dependent Drop Form;
  - The requested change will not be effective prior to the QE date.

- **Deadline**

  - Thirty (30) days from the QE date. The QE date is the date the dropped members gain coverage under the spouse or dependent's employer-sponsored group health plan.
  - The application or Dependent Add Form may be signed by the employee prior to gaining coverage.

- **Supporting documentation needed**

  See *Supporting Documentation* in this Section, under gaining other group health insurance coverage.

E. Change in dependent eligibility

1. Dependent ceases to satisfy Plan eligibility requirements (on account of age, marriage, support and maintenance, etc.)

See *dependent child becomes ineligible*, in this section.

2. Unmarried dependent re-establishes Plan eligibility requirements

- **What can employees do?**

  - Add dependents that re-establish the eligibility requirements under the KEHP;
  - Cannot add tag-alongs;
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, and Commonwealth Premier).

- **Effective date**

  First day of the month following the employee's signature date on the Dependent Add Form or application.

- **Deadline**

  Thirty (30) days from the QE date.

- **Supporting documentation needed**

  - The member must provide the reason the dependent is re-establishing his/her eligibility under the guidelines of the KEHP;
  - At the discretion of the DEI, the member may be requested to provide supporting documentation.

F. Change in residence

1. Employee or spouse changes primary residence

This QE only allows a corresponding election change to the Dependent Care FSA, if the childcare provider changes.

2. Dependent child changes primary residence

See *dependent child becomes ineligible*, in this section.

G. Other events

1. Loss of other group health insurance coverage or <u>other health insurance coverage</u>

Note that some employers may offer a few months of COBRA payments to terminated employees as part of a severance package. It is important to remind your employees that the end of the employer-paid COBRA coverage is NOT a QE that would allow enrollment in the KEHP, as the COBRA continuation coverage period has not been exhausted. ***Only <u>Expiration</u> of COBRA is considered loss of other coverage****.*

The Health Insurance Portability and Accountability Act (HIPAA) was amended to provide new rights and protections for participants and beneficiaries in group health plans. HIPAA contains protections for both health coverage offered in connection with employment (group health plans) and for individual insurance policies sold by insurance companies (individual policies).

Therefore, an employee (or dependent of a covered member) who has experienced a loss of group health insurance coverage or has experienced a loss of other health insurance may join the Plan.

- **What can employees do?**

  - Add themselves and/or their spouse and/or their dependents if the event adversely affects eligibility for coverage under another employer-sponsored group plan or another health plan as listed below;
  - Add tag-alongs;
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, and Commonwealth Premier).

- **Effective date**

  - First day of the month following the employee's signature date on the application or Dependent Add Form;
  - The requested change will not be effective prior to the QE date.

- **Deadline**

  - Thirty (30) days from the QE date. The QE date is the date the added members lose coverage under the health plan;
  - The application or Dependent Add Form may be signed by the employee prior to the loss of coverage.

- **Supporting documentation needed**

  See *Supporting Documentation* in this section, under loss of other coverage.

- **Other – the following information relates to insurance that is not employer-sponsored group health coverage**

  In addition to group health coverage, the following are recognized as valid health coverage:

  - Individual Health Insurance;
  - Short-term, limited-duration insurance also known as "gap" insurance; and
  - Student health insurance.

  In order to enroll in the KEHP, the individual must have experienced one of the following events which caused them to lose coverage from one of the health plans listed above:

  - Maximum benefits level is reached;
  - Insurance agency cancels policy (other than for non-payment);
  - Coverage was provided under COBRA and COBRA has expired;
  - Coverage was non-COBRA and the coverage terminated due to loss of eligibility for coverage (legal separation,

divorce, end of dependent status, death of an employee, termination of employment, reduction in hours) or employer contributions for coverage were terminated; or
- Plan no longer offers benefits for a group of individuals.

Note: The following events will ***NOT*** be recognized as loss of other coverage with special enrollment rights because there was not a change in eligibility:

- Non-payment - choosing to stop payment of a plan for any reason;
- Non-renewal - choosing to stop renewal of a plan for any reason;
- Cancellation of coverage by policy holder for policy holder;
- Cancellation of coverage by policy holder for dependent;
- Increase in cost of coverage; or
- Reduction of contributions or level of benefits.

Note: The following types of insurance are ***NOT*** considered other coverage:

- Coverage only for accident or disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance;
- Workers compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics; or
- Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

2. Judgment, decree or administrative order relating to health coverage for the child (including grandchildren)

- **What can employees do?**

  - Add children to an existing plan if required by a court order, placement papers from the Cabinet for Health and Family Services, or if legal guardianship has been awarded;
  - Add a grandchild – only if legal guardianship or custody has been awarded;
  - Add themselves if they have previously waived coverage and the order stipulates to add child to the employees' plan offered through the employer (upon receipt of an administrative order, the employer must enroll the child on the plan. The employees are responsible for full premiums due) and can't redirect HRA contribution; or
  - Drop children if the order stipulates that coverage is to be provided by the other parent;
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier, and

Commonwealth Select).

- **Effective date**

  - If adding a child at the employee's request (including grandchildren), the effective date is the first day of the month following the employee's signature on the application or Dependent Add Form;
  - If adding a child and employee's consent to enroll the child is not needed (as in the case of a National Medical Support Notice directed to the employer), the effective date is the first day of the month following the date of the administrative order or notice;
  - If dropping a child upon expiration of an order, the effective date is the last day of the month in which the child ceases to meet the eligibility requirements;
  - If dropping a child upon receipt of a new order releasing the employee from providing coverage for the child, the effective date is the last day of the month in which the child ceases to meet the eligibility requirements.

- **Deadline**

  - Thirty (30) days from the date the order or guardianship documents are signed by a judge;
  - Ineligible dependents will be dropped off the plan at the end of their ineligibility date even if the thirty (30) day deadline is not met;
  - Upon receipt of an order directing the employer to enroll an employee's child in the plan, the enrollment will be processed even if the thirty (30) day deadline is not met.

- **Supporting documentation needed**

  See *Supporting Documentation* in this section, under judgment, decree or administrative order relating to health coverage for the child.

3. Employee, spouse or dependent becomes entitled to Medicare or Medicaid (gaining KCHIP is not a valid QE)

- **What can employees do?**

  - Drop coverage for themselves, their spouse and their dependents if they become eligible and enrolled in Medicare or Medicaid;
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, and Commonwealth Premier).

- **Effective date**

The last day of the month in which the employee signs the Dependent Drop Form.

- **Deadline**

  - Thirty (30) days from the date the employee, spouse or dependent becomes entitled to and enrolls in Medicare or Medicaid;
  - The Dependent Drop Form may be signed by the employee prior to the event date; however, the requested change will not be effective prior to the QE date.

- **Supporting documentation needed**

  See *Supporting Documentation* in this section, under employee, spouse or dependent enrolled in employer's health plan becomes entitled to Medicare or under employee, spouse or dependent enrolled in employer's health plan becomes entitled to Medicaid.

4. Employee, spouse or dependent loses entitlement to Medicare, Medicaid, KCHIP or any governmental group health insurance coverage

- **What can employees do?**

  - Add themselves, their spouse and dependents that have lost coverage;
  - Add tag-alongs;
  - Change their plan options (Commonwealth Essential, Commonwealth Enhanced, and Commonwealth Premier).

- **Effective date**

  Last day of the month in which the employee signs the Dependent Add Form or application.

- **Deadline**

  - Thirty (30) days from the date of loss of coverage;
  - The application or Dependent Add Form may be signed by the employee prior to the event date; however, the requested change will not be effective prior to the QE date.

- **Supporting documentation needed**

  See *Supporting Documentation* in this section, under loss of other health insurance coverage that entitles employee or dependent to be enrolled under HIPAA.

H. Cost or coverage changes

1. Dependent Care Cost has significant increase or decrease in cost (change in cost)

This QE only allows a corresponding election change to the Dependent Care FSA. See the Qualifying Event Chart for specific information.

2. Spouse has a different open enrollment period (includes military insurance coverage, except for Veteran's Administration benefits)

- **What can employees do?**
  - Add themselves, their spouse and dependents if spouse elected to drop coverage for them during his/her open enrollment period;
  - Drop themselves, their spouse and dependents if spouse elected to enroll them during his/her open enrollment period.

- **Effective Date**

  The effective date to add or drop will be the same as the effective date of the spouse's Open Enrollment effective dates.

- **Deadline**
  - Thirty (30) days from the QE date;
  - The application, Dependent Add Form or Dependent Drop Form may be signed by the employee prior to the event date;
  - The event date is the last day of the spouse's Open Enrollment period.

- **Supporting Documentation Needed**

  See *Supporting Documentation* in this section, under different open enrollment.

3. Employee/Retiree makes elections during an open enrollment period of another employer or a state sponsored retirement plan (includes military insurance coverage, except for Veteran's Administration benefits)

- **What can employees do?**
  - Add themselves, their spouse and dependents if employee/retiree elected to drop coverage for them during his/her open enrollment period;
  - Drop themselves, their spouse and dependents if employee/retiree elected to enroll them during his/her open enrollment period.

- **Effective date**

  The effective date to add or drop will match the effective date of the spouse's open enrollment effective dates.

- **Deadline**

  - Thirty (30) days from the QE date;
  - The application, Dependent Add Form or Dependent Drop Form may be signed by the employee prior to the event date;
  - The event date is the last day of the spouse's open enrollment period.

- **Supporting documentation needed**

  See *Supporting Documentation* in this section, under different open enrollment.

3. Employee's death

- **What can be done?**

  - Drop coverage for deceased plan holder and covered dependents;
  - The Insurance Coordinator should complete a Health Insurance Update Form indicating the employee's date of death.

- **Effective date**

  - If the deceased employee was enrolled in a Single plan, the coverage ends on the date of death;
  - If the deceased employee was enrolled in a plan with dependents (parent plus, couple or family), the coverage will end at the end of the month of the employee's date of death;
  - **FSA effective date:** the effective date of termination of a Flexible Spending Account due to this QE, is always the date of death.

- **Deadline**

  - Thirty (30) days from the employee's date of death;
  - Upon notification of the employee's date of death, the coverage termination will be processed even if the thirty (30) day deadline is not met.

- **Supporting documentation needed**

  None

- **Other**

  - If the employee was enrolled in a single plan and the employee's date of death is between the 1st and the 15th of the month, the employee's account will be refunded any premiums paid for the month of death.
  - If the employee was enrolled in a single plan and the employee's date of death is between the 16th and the end of the month, the employee's account will not be refunded any premiums paid for the month of death.
  - If the employee was enrolled in a parent plus, couple or family plan, coverage for the dependents will continue through the end of the month of the employee's death. Therefore, the employee's account will not be refunded any premiums paid for the month of death.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

I What is COBRA Continuation Coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1986, or COBRA, provides that virtually all employers who sponsor group health plans must permit covered individuals, who lose coverage under that plan as a result of certain enumerated events, to elect to continue their coverage under the plan for a prescribed period of time on a self-pay basis. Individuals who are entitled to COBRA continuation coverage are known as Qualified Beneficiaries.

II Who is Eligible for COBRA Continuation Coverage?

In general, qualified beneficiaries include employees, their spouses, and dependent children who are covered under the plan the day before the QE occurs. An amendment to the COBRA regulations made by HIPAA, permits children born to, or placed for adoption with, an employee during the period of COBRA continuation coverage to be considered a qualified beneficiary.

Note: If one employee participating in the cross-reference payment option terminates employment, he/she is NOT eligible for COBRA coverage because he/she has not experienced a loss of coverage.

III Who Administers COBRA for the Kentucky Employees Health Plan (KEHP)?

Humana, the KEHP's Third Party Administrator (TPA), has partnered with Ceridian COBRA Continuation Services to administer COBRA for KEHP members. Ceridian uses an online enrollment system called WebQE as the method for COBRA notification. As the Insurance Coordinator, you must enter your members' new hire and COBRA QE information via the Internet based WebQE system. Ceridian will be responsible for COBRA notification letters, enrollment, premium collection, and other COBRA related services.

IV How are Qualified Beneficiaries Notified of their Rights?

COBRA regulations provide that a group health plan is required to provide written notice of COBRA rights to all covered employees and their spouses, if any, when coverage under the plan first commences. The regulations require that group health plans furnish written notice of COBRA rights no later than 90 days after their coverage begins. This written notice may be referred to as either the Initial Notice or the General Notice.

This Initial Notice or General Notice will be mailed to employees by Ceridian COBRA Continuation Services immediately after the Insurance Coordinator enters the employees' new hire information or COBRA QE information on Ceridian's WebQE.

V What are COBRA Triggering Events?

The following are triggering events that employees may experience:

- Termination of employment (for reasons other than employees' gross misconduct) ; and
- Reduction in the employees' hours of employment.

The following are triggering events that employees' spouses or dependent children may experience:

- Termination of employment (for reasons other than employees' gross misconduct) ;
- Reduction in the employees' hours of employment;
- Death of employees;
- Divorce or legal separation from employees;
- Employees' entitlement to Medicare;
- Employers' commencement of a bankruptcy proceeding under Title 11 of the United States Code; and
- Children ceasing to be covered dependent children under the terms of the Plan.

Anytime you are notified of a triggering event, you need to determine whether that event caused the members to lose group health coverage. If it does, then it is a QE, and you will need to enter this information in Ceridian's WebQE Notification System.

Note: If one employee participating in the cross-reference payment option terminates employment, he/she is NOT eligible for COBRA coverage because he/she has not experienced a loss of coverage.

VI What is a COBRA Qualifying Event?

A COBRA QE is one of the triggering events listed above those results in the loss of coverage for a qualified beneficiary. The COBRA regulations provide that a triggering event is a QE only "if, under the terms of the group health plan, the event causes the covered employee, or the spouse or a dependent child of the covered employee, to lose coverage under the plan."

Therefore, when determining if a triggering event caused a loss of coverage, carefully review the facts and relevant documents. When was the loss of coverage? Examine the

Qualifying Event Chart to be certain that it provides a loss of coverage upon the occurrence of a particular triggering event.

NOTE: When employees are granted FMLA leave, the Insurance Coordinator should send the Guidelines for Benefits While on Approved Family Leave memo (Appendix E). While employees are on unpaid FMLA or on Military Leave, they may choose to keep their Flexible Spending Accounts active. Please refer to the chart for specific payment options involved in this choice. With regard to the Healthcare Flexible Spending Account, members on LWOP may elect COBRA on an AFTER TAX basis.

Regarding the Dependent Care Flexible Spending Account, if IRS regulations are met, members on LWOP may continue to file dependent care claims for the remaining funds in their account until the end of the plan year. - Because Dependent Care FSA is not health related (health insurance, dental, vision), COBRA does not apply.

VII When a Qualifying Event Occurs: Who Must Notify Whom?

The employer cannot detect the occurrence of some QEs, because information concerning such events is uniquely within the control of the qualified beneficiary. If the event results in a loss of coverage under the group plan then the COBRA regulations require that the covered employee or other qualified beneficiary notify the Insurance Coordinator of the following events:

- Divorce or legal separation;
- Dependent children ceasing to qualify as dependents under the terms of the plan;
- The occurrence of a second QE after the qualified beneficiary becomes entitled to COBRA continuation coverage with the maximum duration of 18 or 29 months; and
- A determination by the Social Security Administration (SSA) that a covered employee or other qualified beneficiary is disabled, or a subsequent determination by the SSA that the individual is no longer disabled.

The employees or their qualified beneficiaries are required to notify you no later than sixty (60) days after the QE. Failure to notify you in a timely manner will result in unavailability of COBRA continuation coverage for the affected individuals.

The employer must notify the employees of some QEs. If the event results in a loss of coverage under the group health plan, the employer must notify the covered employees and their spouses and dependent children of their COBRA rights for the following events:

- Death of the covered employee;
- Termination of employment (other than for gross misconduct);
- Reduction in the employee's hours of employment;
- The employee's entitlement to Medicare (under Parts A or B, or both); and
- The employer's bankruptcy.

When employees experience any of the above QEs, you must enter all necessary information in Ceridian's WebQE. Ceridian will then mail all necessary notifications and forms within the required timeframes.

VIII How Much Will COBRA Continuation Coverage Cost?

COBRA regulations do not require employers to pay for continuation coverage. Instead, employers are expressly permitted to charge employees 100 percent of the cost of the group health coverage, plus an additional 2 percent, for a total premium of 102 percent. The COBRA rates are included in this manual (refer to Appendix G) and the Personnel Cabinet's Web site. The additional two percent covers the added cost for administering COBRA continuation coverage.

IX What is the Length of the COBRA Continuation Coverage Period?

Listed below are the maximum periods for COBRA continuation coverage:

Qualifying Events that entitle employees to COBRA continuation coverage	**Length of COBRA continuation coverage**
Termination of employee's employment (except for gross misconduct) (Former employee and covered dependents)	18 Months
Reduction of the employee's hours (Former employee and covered dependents)	18 Months
Death of a covered employee (Spouse and covered dependents)	36 Months
Divorce or legal separation from the covered employee (Spouse and covered dependents)	36 Months
Employee becomes entitled to Medicare (Part A, Part B or both) (Spouse and covered dependents)	36 Months
Dependent child covered under plan ceases to be an eligible dependent under the plan	36 Months
Person considered to have total disability, according to the Social Security Administration	29 Months

Page Updated April 2008

NEW EMPLOYEE ORIENTATION

For a printable version of all forms, please go to the Personnel Cabinet's Web site at:

http://personnel.ky.gov/benefits/dei/08planyear/inscoord.htm

I New Employee Orientation

This Chapter has been designed to assist Insurance Coordinators with the enrollment of new employees. All new employees should receive the following information:

- Health insurance handbook;
- Memorandum regarding Notice about Special Enrollment Rights and Notice about Women's Health and Cancer Rights Act (this notice is required by Federal guidelines and can be found in Appendix B; and
- Health insurance checklist (Appendix C). New employees should be given this checklist for review and they should check each item as explained to them by the Insurance Coordinator. This checklist ensures that employees have received the required information and protects the Insurance Coordinator in the event of a discrepancy.

II Health Insurance Checklist

A health insurance checklist is included in Appendix C to ensure consistency in the explanation of Health Insurance and Flexible Spending Account benefits.

- The checklist has been designed to cover essential health insurance information that MUST be given to new employees during the initial benefit orientation session.

- The completed checklist, along with a record of the employees' elections should be made a part of the employees' personnel files as an acknowledgement of receipt of information. Copies of all forms should be given to the employees once they have been completed.

- If your agency is already using a benefit orientation form, make sure you incorporate all topics included on this checklist.

- On the last page of the health insurance checklist, new employees must respond to the question regarding previous employment within the last thirty (30) days with another agency participating in the Kentucky Employees Health Plan (KEHP).

    - If the employees' break in service is thirty (30) days or greater, the employees may make new elections, including changes to the smoking status.

- If the employees' break in service is less than thirty (30) days, the employees may not change their previous elections unless they experience a QE that would allow a permitted mid-year election change.

  For more information regarding processing rules for employees with previous employment through the KEHP, refer to Chapter 1, section X.

III Memorandum Regarding Notice About Special Enrollment Rights and Notice About Women's Health and Cancer Rights Act

Federal law requires that all employees receive notification of the Notice of Special Enrollment Rights and Notice about Women's Health and Cancer Rights Act. A copy of this notice is provided for your assistance (refer to Appendix B).

Page Updated April 2008

LEAVES OF ABSENCE

I Leave Without Pay (LWOP)

A. Starting LWOP

If employees are on leave without pay and they receive pay during the month the leave starts, they will be eligible for the employer contribution for health insurance for the following month. However, if the pay the employees receive is not sufficient to cover the employees' portion of the premium, they must submit a check for the amount due.

If employees are on leave without pay and they do not receive pay during a month, they will not be eligible for the employer contribution for health insurance for the following month.

Any portion of a premium due by the employees must be submitted to the Insurance Coordinator by the 20th of the month. The check must be payable to the Kentucky State Treasurer. The Insurance Coordinator will forward the payment to the Financial Management Branch (FMB).

If the employees have been on LWOP for thirty (30) days or more, the Insurance Coordinator must submit a Health Insurance Update Form to the DEI providing the employees' LWOP begin date and the health insurance coverage termination date.

Employees that lose coverage due to starting LWOP must be entered into Ceridian's WebQE system to receive COBRA information. Note that employees on a cross-reference payment option do not lose coverage upon starting LWOP; therefore, they are not eligible to receive COBRA information. (See section B below)

NOTE: If employees fail to submit appropriate premium payments due within the specified deadline, the ENTIRE POLICY may be canceled. If this occurs, the Insurance Coordinator should request a refund of any employer contribution amount paid.

NOTE: When employees are granted LWOP, the Insurance Coordinator should send the Guidelines for Benefits While on Approved LWOP memo (Appendix D).

NOTE: Worker's Compensation, being on Worker's Compensation or being hurt on the job has no effect on LWOP or your health insurance.

B. LWOP and cross-reference

If the employees on LWOP have selected the cross-reference payment option, the cross-reference payment option must be broken. The DEI will notify the spouse's Insurance Coordinator that one of the cross-reference employees is on LWOP and the remaining employee will be changed to a family (non-cross-reference) plan. The remaining employee will be responsible for payment of the total employee contribution for the family plan.

The Insurance Coordinator does not notify the COBRA Administrator that the employee in a cross-reference payment option has started a LWOP because he/she has not lost health coverage under the Plan.

C. During LWOP

While employees are on LWOP, the following could occur:

1. There is an Open Enrollment period

Employees that are on LWOP during the Open Enrollment period will not receive an Open Enrollment packet.

Employees that elected COBRA will receive Open Enrollment packets from the COBRA administrator.

Upon returning to work, the employees are entitled to receive the Open Enrollment information from the Insurance Coordinator. Employees will have thirty (30) days from the date they return to work to make their Open Enrollment elections.

2. The employees experience a qualifying event

Employees on LWOP that experience a QE must follow the same QE rules as other employees. However, they must request the mid-year election change within thirty (30) days from the return to work date.

The same rules as defined in the Returning from LWOP section below will be applied to determine the effective date of coverage.

D. Returning from LWOP

1. Eligibility for the employer contribution

Employees who return to work after being on LWOP must work at least one (1) day in the month they return to be eligible to receive the employer contribution for the following month.

If the employees do not work one (1) day or more in the month they return, the first day of the second month rule applies.

2. Eligibility for coverage changes

Employees who return to work after being on LWOP will not be eligible to make any changes to their health insurance coverage unless:

- They have experienced a QE and they apply for an appropriate change no later than thirty (30) days from their return to work date.
- They return in a new Plan Year and they were on LWOP during the Open Enrollment period. Employees must apply for a coverage change no later than thirty (30) days after their return.

The Insurance Coordinator must provide the necessary applications upon return.

II Family Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to twelve (12) weeks of job-protected leave for certain family and medical reasons. Employees are eligible for FMLA leave if they have completed twelve (12) months of service and worked or been on paid leave at least 1,250 hours in the twelve (12) months preceding the first day of FMLA leave. This leave is available annually.

Please note that employees who begin unpaid FMLA should not be receiving a paycheck from your agency.

The employees may choose to use paid (annual, sick or compensatory) leave concurrently with FMLA leave (101 KAR 2:102); the employees may choose to use unpaid leave during the FMLA leave; or the employees may choose to reserve ten (10) days of accumulated sick leave prior to being placed on FMLA leave.

NOTE: When employees are granted FMLA leave, the Insurance Coordinator should send the Guidelines for Benefits While on Approved Family Leave memo (Appendix E). While employees are on unpaid FMLA or on Military leave, they may choose to keep their Flexible Spending Accounts active. Refer to the QE Chart in Chapter 3 for the specific payment options.

Regarding the Healthcare Flexible Spending Account, the members on unpaid FMLA may elect COBRA on an AFTER TAX basis.

Regarding the Dependent Care Flexible Spending Account, if IRS regulations are met, the members on unpaid FMLA may continue to file dependent care claims for the remaining funds in their account until the end of the plan year. Due to the fact that Dependent Care FSA is not health related (not health insurance, dental or vision), COBRA does not apply.

NOTE: Worker's Compensation, being on Worker's Compensation or being hurt on the job has no effect on FMLA or your health insurance.

A. Starting FMLA leave

- FMLA leave is not a QE to change health insurance elections.

- When employees begin FMLA leave, the employer contribution for health insurance must continue through the leave period.
- Employees are responsible for the employees' share of the health insurance premiums. Employees may choose to:
  - Cease contributions (terminate entire policy);
  - Prepay the coverage contributions for the FMLA leave period;
  - Choose the pay-as-you-go method. If employees choose this method of payment:
    - The employees' contributions are due at the same time contributions would be due if made by payroll deduction;
    - If employees fail to pay timely, they will be granted a thirty (30) day grace period;
    - If employees fail to pay the required amount by the end of the thirty (30) day grace period, the policy will be automatically terminated back to the last date through which premium was paid; or
  - Choose the catch-up option, which should be agreed to, in writing, by both parties **PRIOR** to the FMLA leave.
- The Insurance Coordinators collect the premium check (payable to the Kentucky State Treasurer) and forward it to:

  Financial Management Branch
  Department for Employee Insurance
  Personnel Cabinet
  501 High Street, 2nd Floor
  Frankfort, Kentucky 40601

B. During FMLA

While employees are on FMLA, the following could occur:

1. There is an Open Enrollment Period

Employees that are on FMLA during Open Enrollment will receive an Open Enrollment packet from the Insurance Coordinator.

Employees that choose to cease contributions are not eligible for health insurance under the Kentucky Employees Health Plan (KEHP) until they return to work.

2. Employees experience a qualifying event

Employees on FMLA that experience a QE will have thirty (30) days from their return to work date to request a status change.

C. Returning from FMLA leave

- Employees returning from FMLA leave must be reinstated to the prior elections unless there has been an intervening status change, in which case, the employees will have thirty (30) days from their return to work date to request a status change.

- If the employees chose to suspend health insurance coverage during the FMLA leave, the employees may be reinstated to the prior elections on the day they return to active status.
- If the employees are reinstated between the 1st and the 15th of a month, the employees will be responsible for payment of premiums for the entire month at the new coverage level, if applicable.
- If the employees are reinstated between the 16th and the end of a month, the employees will not be responsible for payment of premiums for the month of reinstatement at the new coverage level, if applicable.
- If the employees had coverage cancelled due to non-payment of premiums, the employees are to be reinstated to the prior elections upon payment of all past-due premiums.
- If the employees chose suspension of coverage or fail to pay past-due premiums, the agency is to request a refund of the employer contribution for the applicable months.

D. Not returning from FMLA leave

When employees have exhausted FMLA leave, but do not return to work (begin LWOP), the Insurance Coordinator must notify the employees of their COBRA rights (if eligible), regardless of their insurance status during the FMLA leave.

For purposes of COBRA, the date of this COBRA QE is the date the FMLA leave ends. Employees are eligible for eighteen (18) months of COBRA coverage.

III Paid Leave

Employees who have worked or been on paid leave (annual, sick or compensatory time) for at least one (1) day during a month will be eligible for the state contribution for the following month. Paid leave must be used consecutively.

IV Military Leave

Employees called to active military duty are eligible for health benefits through the United States government. The employees' dependents may also be eligible for military health insurance.

A. Starting military leave

Employees may stop their health insurance coverage on the last day of the month in which they are activated with the armed services.

Employees may elect to maintain their current level of health insurance coverage as well as maintain military health care coverage.

NOTE: Refer to the Qualifying Event Chart in Chapter 3 regarding Flexible Spending Accounts during military leave.

If employees have single coverage through the KEHP:

- They may stop their health insurance coverage on the last day of the month in which they are activated with the armed services. This option will allow employees to start their health insurance coverage immediately upon return to active employment. This stop-and-start process will in no way negatively impact employees with regard to pre-existing conditions.

- If employees elect to maintain their current level of health insurance coverage, as well as maintain military health care coverage, they must ensure that the applicable premiums are available via payroll deduction or are received by their Insurance Coordinator no later than the 20th day of the month preceding the coverage month.

If employees have coverage for dependents through the KEHP:

- They may elect to maintain their current level of health insurance coverage and ensure that the applicable premiums are available via payroll deduction or are received by their Insurance Coordinator no later than the 20th day of the month preceding the coverage month.

- They may stop their health insurance coverage on the last day of the month in which they are activated with the armed services. This option will allow employees to start their health insurance upon return to active employment. This stop-and-start process will in no way negatively impact employees with regard to pre-existing conditions.

Employees called to active duty must elect one (1) of the preceding options for their health insurance during the time they are activated. The only option that may be affected by the minimum or maximum length of activation is dependent coverage and the employees are responsible for that verification. All premiums due upon return from active duty will be determined by the date of return to active employment.

B. During military leave

If employees elect to maintain their health insurance while on leave, they must ensure that the applicable premiums are available via payroll deduction or are received by their Insurance Coordinator no later than the 20th day of the month preceding the coverage month.

Note: Refer to Qualifying Event Chart in Chapter 3 for information regarding Flexible Spending Accounts while on military leave.

C. Returning from military leave

Employees returning from military leave will have all benefits (health insurance and Flexible Spending Accounts) reinstated upon their return, effective the date they return, (first day of the second month rule does not apply) without any waiting period for pre-existing conditions.

Note: Employees returning from military leave may delay the reinstatement of their prior elections until military coverage ends (at the employees' option). During that time, employees may waive coverage and enroll in a stand-alone until Tricare ends. Employees electing this option will have to present supporting documentation of the military coverage end date.

Employees returning between the 1st and the 15th of the month will need to pay the employee portion (family, couple, parent plus or single, if applicable) of the insurance premium for the month of return. Employees returning on the 16th of the month or later will be exempt from paying the premium for the month of return. In both cases, the employees will pay the employees' share of the premium for subsequent months.

PREMIUM BILLING AND RECONCILIATION

I Overview

The DEI has implemented a Premium Billing and Reconciliation (PB&R) system to facilitate the reconciliation and management of health insurance enrollment data and premiums. By managing all premiums, the PB&R system supports the Commonwealth's self-funded insurance model.

In order to manage the overall functioning of the system, the Personnel Cabinet, through the DEI, established the **Financial Management Branch (FMB). The FMB is responsible for overseeing the following areas:**

- Creation of health insurance bills and administration fee bills using Web-billing;
- Reconciliation of health insurance coverage with all agencies and administrators;
- Posting of all premium payments and adjustments; and
- Reporting and resolution of discrepancies.

The Flexible Benefits Branch (FBB) is responsible for overseeing the following areas:

- Reconciliation of FSA and HRA elections with all agencies and administrators;
- Posting of all premium payments and adjustments; and
- Reporting and resolution of discrepancies.

II Health Insurance Billing Statements

A. State government agencies

State government agencies do not receive a bill statement. The FMB receives a file extract from the state payroll system (UPPS). Health insurance, FSA and HRA premiums and administration fees are posted into the PB&R system automatically from this file.

Once the file extract has been loaded into the PB&R system, the FMB and FBB reviews the results and notifies each state agency's Insurance Coordinator about any premium discrepancies.

B. Boards of education

- **Employee portion of the health insurance and FSA premiums**

  Boards of education have a monthly bill statement (semi-monthly for FSA/HRA) generated by PB&R's Web Billing database **(the web address is:**

Page Updated April 2008

http://personnel.ky.gov/**)** for the employee portion of the health insurance, FSA and HRA premiums only.

Insurance Coordinators are responsible for reconciling the monthly web billing statements (or semi-monthly for FSA/HRA) to deductions made from the board of education payroll system and make any necessary changes to the web bill:

- For example, the ***Remove*** function in Web Billing indicates that a person on the bill was removed. An example of removing a record would occur if the employee terminates employment or transfers and the person still shows on the bill or if the employee did not make a payment for the month. Note that if you remove a record from a bill but the appropriate action has not been taken to change the record in the Group Health Insurance system (GHI), the record will appear again on the next month's web billing statement. If the termination is due to termination of employment, the IC should log into the web enrollment system and click on *IC Functions* to complete termination of health coverage or FSA/HRA within ninety (90) days. If the termination is past ninety (90) days, the IC will need to complete an Update Form and fax it to the Enrollment Information Branch at (502)564-1085, or if for an FSA/HRA the IC will need to complete a Flexible Spending Account Qualifying Event Change Form and fax it to the Flexible Benefits Branch at 502-564-0364.

  For other terms that don't meet these criteria, the IC will need to contact DEI.

- **Please note that DEI no longer processes terminations from the MUNIS Remittance file that the ICs submit monthly to the Kentucky Department of Education (KDE). It is the Board of Education's responsibility to reconcile the monthly web-billing statement and process terminations in a timely manner. The Enrollment Information Branch (EIB) must be notified of all terminations in a timely manner. For any questions concerning your monthly web billing statement, please contact FMB at (502)564-9097.**

It is important to note that the premiums received MUST match the monthly or semi-monthly web billing statement.

- **Employer portion of the health insurance or HRA premiums**

  KDE pays the employer portion of the health insurance or HRA premiums and the administration fees. ICs or Payroll Officers with questions related to MUNIS need to contact the Kentucky Department of Education (KDE) at (502)564-3846.

C. Health departments and quasi governmental agencies

Currently, Health Departments do not participate in the KEHP Flexible Spending Account Program, and only a limited number of Governmental Quasi agencies participate.

The PB&R's Web Billing system generates monthly (semi-monthly for FSA/HRA) bill statements for health departments and quasi governmental agencies **(**http://personnel.ky.gov/**).**

Insurance Coordinators are responsible for reviewing the monthly (semi-monthly for FSA/HRA) web billing statements for accuracy and making any necessary changes.

- For example, the *Remove* function in Web Billing indicates that a person on the bill was removed. An example of removing a record would occur if the employee terminates employment or transfers and the person still shows on the bill or if the employee did not make a payment for the month. Note that if you remove a record from a bill but the appropriate action has not been taken to change the employee's record in the Group Health Insurance system (GHI), the record will appear again on the next month's web billing statement. If the termination is due to termination of employment, the IC should log into web enrollment and click on *IC Functions* to complete termination of health coverage, FSA or HRA within ninety (90) days. If the termination is past ninety (90) days, the IC will need to complete an Update Form and fax it to the Enrollment Information Branch at (502)564-1085. If the termination is for an FSA or HRA, the IC will need to complete the Flexible Spending Account Qualifying Event Change Form, and fax it to the Flexible Benefits Branch (FBB) at 502-564-0364.

  For other terminations that do not meet this criterion, the IC will need to contact DEI.

III Detailed Description of the Billing Statements

A. Boards of education

- A user guide to assist with processing web bills for health insurance and FSA is located on the Personnel Cabinet's Web site.
  a) http://personnel.ky.gov/
  b) Under *Benefits* (located in the middle of the page) click on *Health Insurance*
  c) Click on *Your KEHP Online Access on the top right of the screen.*

B. Health departments

- A user guide to assist with processing web bills for health insurance and FSA is located on the Personnel Cabinet's Web site. Go to the 2007 Health Insurance tab, click on Insurance Coordinator then Training.
  a) http://personnel.ky.gov/
  b) Under *Benefits* (located in the middle of the page) click on *Health Insurance*

c) Click on *Your KEHP Online Access on the top right of the screen.*

Note that each health department's web bill displays administration fees that are not included in the total owed on the bill. Each health department is responsible for reviewing the administration fees for accuracy. For example, an employee that should be terminated but is still listed on the web billing statement. A separate web bill for all health departments' administration fees is generated for the central office of the health department.

For questions concerning your monthly (or semi-monthly for FSA/HRA) web billing statement, please contact the Financial Management Branch (health insurance) at (502)564-9097, or the Flexible Benefits Branch at 502-564-0350.

C. Quasi governmental agencies

- A user guide to assist with processing web bills for health insurance and FSA is located on the Personnel Cabinet's Web site. Go to the 2007 Health Insurance tab, click on Insurance Coordinator then Training
  a) http://personnel.ky.gov/
  b) Under *Benefits* (located in the middle of the page) click on *Health Insurance*
  c) Click on *Your KEHP Online Access on the top right of the screen.*

Note that if your agency's HRA and FSA programs are administered by the Department for Employee Insurance (DEI), you are responsible for completing the HRA and FSA web bill online. This bill is a separate statement from the health insurance web bill.

For questions concerning your monthly web billing statement, please contact FMB at (502)564-9097.

IV Premium Refunds

A. When to request a refund

The following list, while not all-inclusive, defines when a refund may be requested:

- A check is issued in error;
- An employee terminates at the end of the month and one-half the premium for the following month is deducted and sent to the DEI;
- An employee is enrolled with the wrong option or coverage level;
- The occurrence of a QE, since the KEHP is a pre-paid health insurance plan (see specific information under C below); or
- An employee is ineligible or becomes ineligible (see specific information under C below).

Page Updated April 2008

B. Time limits for refund requests

Refunds will be restricted to the beginning of the current plan year to a maximum period of three (3) months or ninety (90) days, except in the event of the death of a covered person (see C below). Note that any mid-year election change resulting in the termination of a covered person will be effective on the date as designated under the terms of the KEHP. Therefore, if the DEI receives notification of a termination more than ninety (90) days after the event causing the termination, the premium will be refunded as shown in the following table:

Notification received in:	Count from:	Months for which premium is to be refunded:
January	January 31	January
February	February 28	January and February
March	March 31	January, February and March
April	April 30	February, March and April
May	May 31	March, April and May
June	June 30	April, May and June
July	July 31	May, June and July
August	August 31	June, July and August
September	September 30	July, August and September
October	October 31	August, September and October
November	November 30	September, October and November
December	December 31	October, November and December

***NOTE*: If a refund is due, you can either take it as a credit to your account or request it in writing from the FMB, or FBB. You must NOT do BOTH!**

C. Refunds due to eligibility changes

- **Death of a covered spouse.** Employees that experience the QE of death of a spouse may be eligible for a premium refund, with no time limits, as follows:
    - If the event date is between the 1st and the 15th of a month, the employee will be entitled to any refund for the month of death resulting from a plan level change (family to parent plus or couple to single).
    - If the event date is between the 16th and the end of a month, the employee will not be entitled to any refund resulting from a plan level change (family to parent plus or couple to single) due to the spouse's death.
- **Death of a covered dependent child.** Employees that experience the QE of death of a dependent child may be eligible for a premium refund, with no time limits, as follows:
    - If the event date is between the 1st and the 15th of a month, the employee will be entitled to any refund for the month of death resulting from a plan level change (parent plus to

single or family to couple).
  - If the event date is between the 16th and the end of a month, the employee will not be entitled to any refund resulting from a plan level change (parent plus to single or family to couple) due to the dependent's death.

- **Death of a covered employee.** The account of a deceased employee will be reimbursed funds, with no time limits, as follows:
  - If the employee was enrolled in a single plan and the employee's date of death is between the 1st and the 15th of the month, the employee's account will be refunded any premiums paid for the month of death. If the employee was enrolled in an FSA/HRA and the date of death is between the 1st and the 15th of the month, the employee will receive a refund for the paid premiums of the 16th through the 31st of the month.
  - If the employee was enrolled in a single plan and the employee's date of death is between the 16th and the end of the month, the employee's account will not be refunded any premiums paid for the month of death.
  - If the employee was enrolled in a parent plus, couple or family plan, coverage for the dependents will continue through the end of the month of the employee's death. Therefore, the employee's account will not be refunded any premiums paid for the month of death.

- **Dependent child becomes ineligible**. Employees that experience the QE of dependent child becomes ineligible will be entitled to a refund. However, the *time limits for refund requests* rules detailed in B above apply.

D. Miscellaneous

The DEI will issue refund checks for any erroneous overpayments. Refund checks, except for those to quasi governmental agencies and school districts, will be made payable to:

- The Kentucky State Treasurer, if the overpayment is to the employer;
- The employee, if the overpayment is the employee's portion; or
- Separate checks for both the employee and the Kentucky State Treasurer, if there is an overpayment of both employee and employer payments.

Refund checks will be sent to the appropriate Insurance Coordinator or payroll officer no later than thirty (30) days from receipt of the request for refund.

Refund requests may be initiated by either the Insurance Coordinator or the Payroll Officer.

V Other Payment Information

A. When will I be able to work my web billing statement?

Your billing contacts should receive a system generated email letting them know that the web billing statement has been generated. If your billing contacts have not received an email by the 22nd of the month letting them know that the bill statement is available, please check the Web Billing system to see if the statement is available.

B. To whom do I make the check(s) payable?

If you pay by paper check, make checks payable to the Kentucky State Treasurer.

Please note:

- **We do not accept cash**
- Everyone is encouraged to use the Web Billing function called *Easy Pay*. This function allows the agencies to do an ACH at no cost to the agencies (see the Web Billing User Guide).
- One payment can be submitted for both health insurance premiums and administration fees. However, a separate check must be issued for FSA/HRA premiums.
- The administration fees for health departments and school boards are paid by a central location; therefore, they are not included in the bill statement total.

C. Where do I mail the payment(s)?

Payments must be mailed to:

Personnel Cabinet
Financial Management Branch
501 High Street, 2nd Floor
Frankfort, Kentucky 40601

D. Who do I contact if I have questions?

Contact the Financial Management Branch staff at (502) 564-9097. Contact the Flexible Benefits Branch at 502-564-0350.

REPORTS AND ONLINE ENROLLMENT

Throughout the year, the Department for Employee Insurance (DEI) will generate reports to the Insurance Coordinators. These reports are developed within the Group Health Insurance (GHI) database and are provided to inform Insurance Coordinators on applications processed through this database system. A description of each report and detailed information regarding what you are to do with each report are provided below.

I TEFRA - for Active State Employees Age Sixty-five (65) and Older

Every month, the Personnel Cabinet's Payroll Branch generates a report of all active state employees who will turn age sixty-five (65) in the next three (3) months. The DEI's Member Services Branch distributes this report to appropriate Insurance Coordinators. The TEFRA letter in Appendix A should be mailed to the employees on that list. The letter details how TEFRA affects the employees and what their options are at age sixty-five (65).

II GHI Automatic Emails

The GHI system automatically generates email notifications to Insurance Coordinators when actions that affect the members' payroll deductions are taken on members' records. Actions such as accepts, terminations or pends will generate an email to the Insurance Coordinator on record. If you have submitted applications or change requests to the Enrollment Information Branch (EIB) and have not received automatic emails within a reasonable period of time, notify the EIB immediately.

III Pended Records

This report is generated weekly and is mailed to each agency's health Insurance Coordinator. If employees' applications have been pended for any reason, you will receive a report listing their Social Security Number, name, middle initial, the date it was pended and a note written by the EIB processor providing details about the pend action. The report also contains a message indicating the length of time the record has been in pended status and the action that will be taken if the issue is not resolved within the deadline. Pended records must be resolved within sixty (60) days of the original pend date. Records in pended status for a period greater than sixty (60) days will be rejected. This will be done by the EIB and documentation received after the deadline will not be accepted. If an application has been rejected, you will be notified in writing by the EIB.

The deadlines for QEs do not change because of a pend action. Most QEs must be signed within thirty (30) days after the event date. If a Dependent Add Form or a

Dependent Drop Form has been signed within the deadlines, but it has been pended for supporting documentation or other reason, members will have up to sixty (60) days from the original pend date to submit the proper documentation or information requested.

IV Ineligible Dependents (Age 24)

This report is generated in December of each year. It includes all dependents that will turn twenty-four (24) during the following calendar year. These dependents will be automatically terminated from the KEHP effective December 31. The DEI will also make changes to the employees' health insurance level based on the number of dependents remaining on the plan. The ineligible dependents are eligible to receive COBRA notification. The notification will be mailed by Ceridian, the Commonwealth's COBRA administrator.

If employees have other eligible children covered under the plan, coverage will remain at the same level. If the child to be dropped is the only dependent child on the employee's plan, the planholder will be assigned a plan as follows:

- A parent plus plan will be assigned to a single plan*;
- A family plan will be assigned to a couple plan;
- A family paying by cross-reference will be assigned to two single plans*.

* A single Commonwealth Essential plan is not available. Therefore, Commonwealth Essential plans will become Commonwealth Enhanced plans.

V Web Reporting

You may log on to the Web site *Your KEHP Online Access* at www.openenroll.ky.gov to access your employees' records and to generate varied reports pertinent to your agency. The reports provided by the online system contain information regarding your employees' status in the GHI system (active, pended, terminated, unedited or waived). It will also give you the ability to print a complete listing of your agency's employees, including their plan selection, plan cost, and Flexible Spending Account information, if applicable.

VI Web Enrollment System - *Your KEHP Online Access*

Your KEHP Online Access is available throughout the year to Insurance Coordinators and to employees to access and enter their healthcare and flexible benefits elections. Retirees do not have access to the web enrollment system.

Insurance Coordinators may use the web enrollment system to perform administrative functions and other Insurance Coordinator functions including viewing and changing your employees' elections, adding new employees and terminating coverage.

A. Performing administrative functions

Your KEHP Online Access provides you with a variety of administrative functions that include reviewing and updating your own benefits and enrollment

information, resetting your employees' accounts and obtaining your agency statistics and reports.

B. Viewing and changing your employees' elections

This function allows you to review your employees' elections and to make any appropriate changes to your employees' demographic and other information. Keep in mind that any changes made to employees' records via the web enrollment system must be supported by paper documentation signed by the employees.

C. Adding new employees

This function provides you with three (3) options to enter new employee information.

- You may enter the employee's social security number, name, date of birth, company number and hire date only. This is referred to as the new employee shell;
- You may enter the new employee shell and all demographic information; or
- You may enter the above information plus all enrollment information. If you elect to enter all enrollment information, ensure that you have a paper application signed by the employee within the appropriate deadline as supporting documentation.

D. Terminating coverage

This function allows you to enter your employees' termination of employment only. Terminations due to transfers, retirement, death, beginning a leave of absence or employees enrolled in a cross-reference payment option, and corrections to previously reported termination dates must not be entered using the web enrollment system. Report those terminations to the Enrollment Information Branch using an Update Form.

E. Accessing *Your KEHP Online Access*

- To access *Your KEHP Online Access*, go to **https://openenroll.ky.gov** and enter your login credentials.
- To access enrollment directions for Insurance Coordinators and for employees, you may either click on the links found after the log in screens, or you may go to **http://personnel.ky.gov/benefits/dei/07planyear/webenrollment.htm**

Page Updated April 2008

FLEXIBLE BENEFITS

The Kentucky Employees Health Plan Flexible Spending Account (FSA) Program, which is provided through a Section 125 plan, allows participating employees to pay for eligible healthcare and dependent care expenses with pre-tax dollars.

The Kentucky Employees Health Plan (KEHP) currently offers the following Flexible Spending Accounts to all eligible employees:

- Healthcare FSA;
- Dependent Care FSA; and
- Health Reimbursement Account (HRA)

Eligible employees who wish to participate in any of the Flexible Spending Account programs MUST complete an online or paper enrollment **EVERY YEAR** during the annual open enrollment period. Enrollment is **NOT automatic** and enrollment elections **WILL NOT** carry-over to the next plan year.

Section 125 plans are federally regulated and changes are not permitted on these plans outside of the annual Open Enrollment period, unless employees experience an appropriate Qualifying Event (QE). QEs are also governed by federal guidelines.

The Qualifying Event Chart in Chapter 3 outlines all of the permitted changes in a Healthcare FSA, Dependent Care FSA, and Health Reimbursement Account (HRA).

I Eligibility Requirements

Employees who are eligible for the state-sponsored health insurance coverage may enroll in the Healthcare Flexible Spending Account or the Dependent Care Flexible Spending Account during Open Enrollment or as a result of an applicable QE. (Refer to the Qualifying Event Chart in Chapter 3 for applicable events that would allow enrollment into the Flexible Spending Account program).

Employees who are eligible for state-sponsored health insurance coverage, but choose to waive such coverage, will be eligible for the stand-alone Health Reimbursement Account (HRA) with an employer contribution of $2100 per year (no employee funds may be directed to the HRA).

Page Updated April 2008

Employees who are eligible for the state-sponsored health insurance coverage and who enroll in the Commonwealth Select Plan will be eligible for the HRA that is embedded in the health insurance plan. The HRA employer contribution amount will be:

- $1,000 Single
- $1,500 Parent Plus
- $1,500 Couple
- $2,000 Family

NOTE: Employees who currently have a Health Savings Account (HSA) with their spouse's employer are NOT eligible to have an HRA, with the KEHP, due to IRS guidelines, which govern cafeteria plans.

Employees may enroll in the FSA program within thirty (30) days of their employment date or thirty (30) days of their eligibility for benefits date. The effective date will be the first day of the second month from the date of hire (i.e. employee hire date is February 25; employee's effective date would be April 1). Indicate the effective date on the Enrollment Application and adjust the number of pay periods accordingly by using the chart in section IV below.

Note that active employees who are covered spouses on a hazardous duty retiree's plan will not be eligible to direct the state contribution into an HRA. For more information, refer to Chapter 2, section III, Double Dipping.

Retirees are not eligible to participate in the FSA programs.

II. Redirection of the Employer Contribution

Redirection is the ability of an employee to stop employer funds from going into a stand-alone HRA in order to start receiving an employer contribution toward a health insurance plan as a result of experiencing a permitted qualifying event (QE).

NOTE: There are NO QEs that allow a member to stop a health insurance plan in order to enroll in a waiver with a stand-alone HRA. (See Chapter I, section A, 2 for more information)

III Timely Filing of Claims

All claims must be submitted by March 31st of the following Plan Year. However, services will not be covered unless the employees are eligible for benefits on the date services are rendered. For example: Employees who have coverage from 1/1 - 5/31, can turn in claims for reimbursement up to 3/31 of the next calendar year, provided the dates of service of such claims are between 1/1 - 5/31.

Page Updated April 2008

IV UPPS Guidelines for Deductions

Hire Date	Effective Date	# of Pay Periods Remaining in PY	Pay Period
November	January	24	12/31
December	February	22	1/31
January	March	20	2/29
February	April	18	3/31
March	May	16	4/30
April	June	14	5/31
May	July	12	6/30
June	August	10	7/31
July	September	8	8/31
August	October	6	9/30
September	November	4	10/31
October	December	2	11/30

Employees who previously worked for a KEHP participating agency and had less than a thirty (30) day break in service, and return to employment, will have the same elections prior to their break in service, unless an event has occurred that would allow a change.

Employees, who previously worked for a KEHP participating agency and had a break in service of thirty (30) days or greater, and return to employment, will be allowed to make new elections.

Employees who enroll in a Flexible Spending Account (Healthcare or Dependent Care) and/or HRA during Open Enrollment **and who terminate employment before coverage is effective on January 1st,** will not be offered COBRA coverage under the Flexible Spending Account for the upcoming plan year; however, they will be offered COBRA coverage for the prior year in which employment terminated. If they return to work after the plan year begins with less than a thirty (30) day break in service, they will have the same elections that they had chosen during the Open Enrollment period. Employees with a break in service of thirty (30) days or greater will be eligible to enroll as new employees, with an effective date of the first day of the second month after the date of employment.

V Payroll Processing

A. Open Enrollment

Payroll deductions will be downloaded from the Department for Employee Insurance's (DEI) database. Insurance Coordinators do not set up deductions during the Open Enrollment period unless instructed by the DEI. The DEI will send Open Enrollment information electronically to the Third Party Administrator.

B. Initial enrollment (New Hire) and Special Enrollment (Change in Status/Qualifying Events)

For information on enrollment outside the Open Enrollment period (i.e. new hires and Change in Status), contact the DEI. Payroll deductions for initial enrollment will be set up by the DEI.

VI Contribution Amounts

A. Healthcare FSA

The minimum allowable monthly contribution is $10 and the maximum allowable yearly contribution is $5,000.

B. Dependent Care FSA

The maximum yearly contribution amount depends on the employee's tax filing status as listed below:

- married filing separately → $2,500
- single and head of household → $5,000
- married and filing jointly → $5,000

C. Health Reimbursement Account (HRA)

Employees, who waive their health insurance coverage, if eligible, receive $2100 annually from their employer into an HRA.

Employees who have an embedded HRA with their Commonwealth Select Plan receive the amount as indicated in section I of this Chapter and on the Benefits Grid in the Health Insurance Handbook.

VII Types of Leave and Flexible Spending Accounts

A. Leave without pay (LWOP)

1. Break in service of less than thirty (30) days

Employees on LWOP that do not receive a paycheck during a pay period will not be eligible for the employer contribution for the Health Reimbursement Account (HRA) for that pay period. It will be the employees' responsibility to pay the contribution (employer/employee) for that pay period.

Employees should submit checks made payable to the Kentucky State Treasurer by the 30th of the month to:

Personnel Cabinet
Department for Employee Insurance
Flexible Benefits Branch
501 High Street, 2nd Floor
Frankfort, Kentucky 40601

Note: If employees do not want a break in service but fail to submit a check by the due date, the total contribution should be deducted from the first paycheck they receive once they return from LWOP. If the employees' contribution is an amount greater than anticipated, consult with the employees to determine the preferred method of payment to make current.

2. Break in service of thirty (30) days or greater

If any employees are on LWOP for thirty (30) or more days, the Insurance Coordinator should do the following:

- Submit a Health Insurance Update Form to the DEI providing the employees' LWOP begin date and the FSA termination date (term date for FSA is the same as the LWOP begin date).
- Enter the employees' QE information on the COBRA Administrator's WebQE online system.

3. Returning from LWOP

Employees returning from LWOP will be reinstated to the same elections prior to LWOP unless they experience a QE and request a change within the required time limit for the event; they return in a new plan year; or they return after the open enrollment period and apply for a coverage change no later than thirty (30) days after the return date.

Reinstatement of employees' prior elections can be accomplished with one of the following methods (employees' choice):

- Proration: employees may elect to continue at the same monthly contribution amount prior to the LWOP termination date and the annual amount is reduced by the contributions missed; or
- Reinstatement: employees may elect to make-up the missed contributions.

4. Open Enrollment occurs while on LWOP

If an employee is on LWOP during Open Enrollment, the Insurance Coordinator does not need to send an open enrollment packet. The packet is to be given upon the employee's return from LWOP.

If the employees did not elect COBRA, they are not eligible for the Flexible Spending Account through the KEHP until they return to work.

The COBRA administrator will send Open Enrollment information to the employees who elected COBRA.

5. Qualifying Events during LWOP

If employees are on LWOP and they experience a QE, the same status change rules apply. However, the employees may request the mid-year election change within thirty (30) days of the return to work date.

NOTE: Employees are not eligible to file for reimbursement of Dependent Care expenses incurred while on LWOP.

6. Eligibility for the employer contribution for the HRA

Employees who return to work after being on LWOP must work at least one (1) day in the month they return to be eligible to receive the employer contribution for the HRA in the following month.

B. Family Medical Leave Act (FMLA)

When employees are granted FMLA leave, the Insurance Coordinator should send the *Guidelines for Benefits while on Approved Family Leave* letter in Appendix E.

1. Beginning FMLA leave

FMLA leave is not a QE to make any changes to the healthcare FSA.

When employees begin FMLA leave, the employer contribution for the HRA is to continue through the leave period.

The employees are responsible for their Healthcare Flexible Spending Account. The employees may choose to:

- Cease contributions (terminate the entire contribution);
- Prepay the total contribution for the FMLA leave period;
- Choose the pay-as-you-go method. If the employees choose this method of payment, the employees' contribution is due at the same time the contribution would be made by payroll deduction. Employees who fail to pay timely will be granted a thirty (30) day grace period to pay the contributions. Employees who fail to pay the required amount by the end of the thirty (30) day grace period, will have the Healthcare Flexible Spending Account automatically terminated back to the last date through which contributions were paid. The employees will not be able to participate for the remainder of the year.

  When the employees are on FMLA leave, forward contribution checks to:

  Personnel Cabinet
  Department for Employee Insurance
  Flexible Benefits Branch
  501 High Street, 2nd Floor
  Frankfort, Kentucky 40601

2. Returning from FMLA Leave

Upon the employees' return from FMLA leave, the employees must be reinstated to their prior elections before FMLA leave unless there has been

a status change (birth, adoption, etc), in which case, the employees are held to the thirty (30) day rule for requesting the change.

The employees may choose one of the following for their FSA:

- Proration: Employees may elect to continue the same monthly contribution as prior to the FMLA leave and the annual amount is reduced by the contributions missed; or
- Reinstatement: Employees may elect to make-up the missed contributions.

3. Not returning from FMLA Leave

When employees have exhausted their FMLA leave, and do not return to work (begin LWOP), the Insurance Coordinator must notify the employees of their COBRA rights, regardless of the employees' FSA status during the FMLA.

For purposes of COBRA, the date of the COBRA QE is the date the FMLA leave ends. Employees are eligible for COBRA through the end of the Plan Year.

C. Military leave

Employees may discontinue their contributions to the Flexible Spending Account Program when they are activated with the armed services. This option will allow the employees to be reinstated when returning to employment from military leave. The employees may select one of the following upon return:

- **Proration:** employees may elect to continue at the same monthly contribution prior to military leave and the annual amount is reduced by the contributions missed; or
- **Reinstatement:** employees may elect to make-up the missed contributions.

Employees returning between the 1st and the 15th of the month will need to pay the entire employees' contribution for FSA. The employer will be required to pay HRA contributions for the month in which the employees return.

Employees returning on or after the 16th of the month will only need to pay half of the election for FSA. The employer will be required to pay the employer's portion of the contribution for HRA for the month in which the employees return.

VII Forms to Use

- Members will complete an Enrollment Application upon hire, if they are electing new coverage, waiving and enrolling in a new stand-alone HRA, selecting a new payment option, or requesting an option change based on experiencing a QE.
- Members will complete a Dependent Add or Drop Form if they are electing to add or drop dependents due to experiencing a QE.
- All forms are available on the web at www.kehp.ky.gov. Look under the Insurance Coordinator section.

VIII The Humana*Access* VISA Cards (HAC)

A. Who will receive a HAC?

Employees who have elected an FSA, the Commonwealth Select plan, or who have waived health insurance coverage and have an HRA will receive a Humana*Access* VISA Card (HAC) to pay for covered eligible expenses.
Employees may use the HAC card at the time they receive a covered service by simply swiping the HAC card just like they are making a purchase. There is no PIN provided with the HAC card; therefore, they must select "credit" at the time of purchase.

Employees must activate their HAC cards before they can be used to pay for covered eligible expenses.

B. Multi-year cards

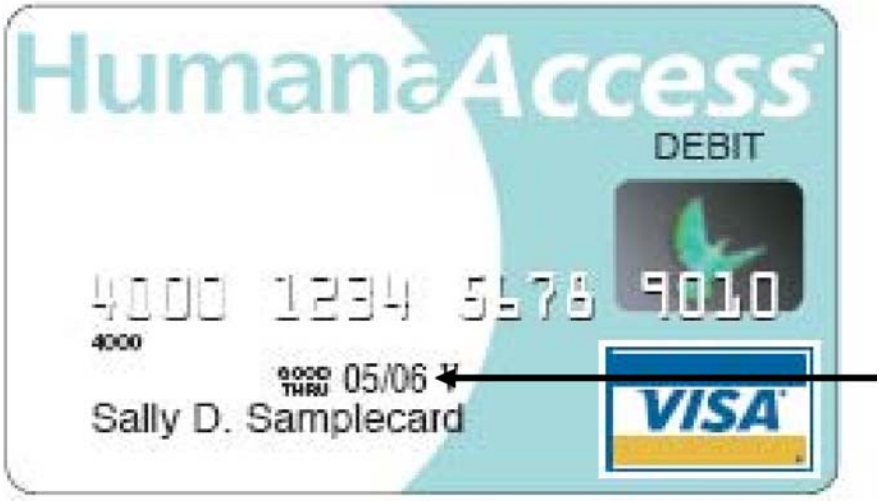
HAC cards are issued for multiple years, and are not reissued every Plan Year. If employees have funds in their account and they are making an eligible purchase, the HAC card will continue to work from year to year. The multi-year card will reduce the number of new cards the members will receive. In addition, it will give the members the security of knowing that they will have continual access to their funds as new plan years arrive.

C. Types of cards

The card shown in **Diagram A** is the standard Humana*Access* VISA Card. Employees will receive this card if they are:

- The Planholder under the Commonwealth Select plan, which has an embedded HRA; or
- The Planholder under the Commonwealth Essential, Commonwealth Enhanced, or Commonwealth Premier plans, and have elected to contribute their own funds to an FSA for the current Plan Year.

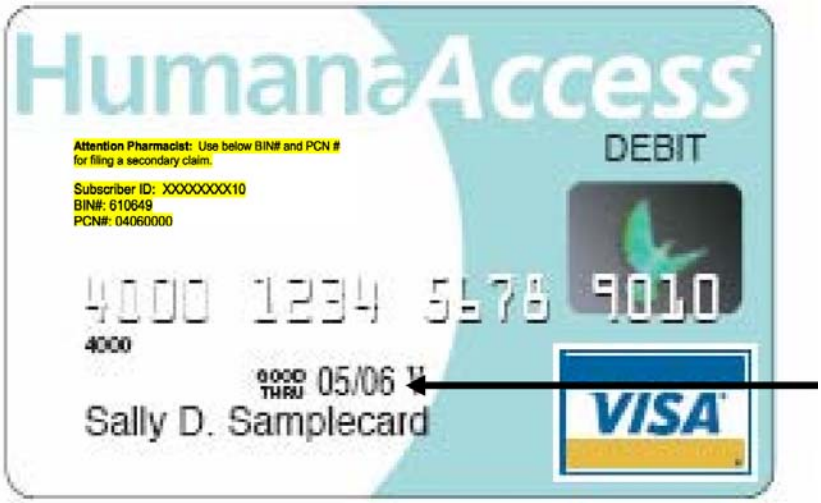
Diagram A



The card shown in **Diagram B** has additional information for pharmacists on the upper left hand corner, to assist in using the card at the pharmacy when purchasing prescription drugs. Employees will receive this card if they are:

- the spouse in a cross-reference payment option under any of the four medical plans (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier, or Commonwealth Select), and have elected to contribute their own funds to an FSA for the current Plan Year; or
- the Planholder and waived medical coverage with the Kentucky Employees Health Plan, and elected to have the employer contribution directed to the stand-alone HRA. In this case, the card in **Diagram B** is to be used for secondary payer claims - either at a pharmacy or a provider's office. Since the employees have health insurance elsewhere, they should provide their health insurance I.D. card along with the Humana*Access* VISA card. When using the card at a pharmacy that participates in the Humana Spending Account Secondary Payer Pharmacy Network, the pharmacist can identify the employees' health insurance carrier and their copay or coinsurance amounts. The transaction is completed in one process without further need for claim substantiation.

Diagram B



IX Flexible Spending Account Contacts

A. Plan administrator

Humana Spending Account Administration
PO Box 3967
Louisville, KY 40201-3967

Customer Service:
(800) 604-6228
(800) 905-1851 (FAX)

B. Paper reimbursement requests

If employees do not use the Humana*Access* VISA card to pay for out of pocket expenses, they may mail or fax paper claims for reimbursement of expenses incurred to the above address or fax number, respectively. Reimbursement forms may also be found in our Web site at www.kehp.ky.gov.

C. Flexible Benefits Branch

If you or your employees have questions regarding eligibility for your Flexible Spending Account, contact:

Personnel Cabinet
Department for Employee Insurance
Flexible Benefits Branch
501 High Street, 2nd Floor
Frankfort, KY 40601
(502) 564-0350/ (502) 564-0351
(502) 564-0364 (FAX)

Glossary of Terms

Change in Status – Any event that changes the following:

(a) legal marital status (marriage, death of spouse, divorce, legal separation or annulment);
(b) number of dependents of qualifying individuals (for Dependent Care Assistance only), (birth, adoption, placement for adoption, or death of a dependent child);
(c) employment status (commencement or termination of work; strike or lockout; commencement or return from an unpaid leave of absence; or any benefit eligibility condition that depends on employment status, whereby an employment status change would result in an individual either becoming, or ceasing to be, eligible under a plan for Employee, Spouse or Dependent);
(d) dependent status (employee's dependent child satisfies, or ceases to satisfy, coverage requirements due to attainment of age or any similar circumstance);
(e) residence or work site (change in Employee's, Spouse's or Dependent's place of residence or employment); and
(f) such other events as may be permitted by law or regulation.

COBRA – The Consolidated Omnibus Budget Reconciliation Acts of 1986, as amended, including parallel provisions as outlined in Title XXII of the Public Health Service Act. COBRA allows employees to continue their group health insurance coverage for a period of time.

Contract Year – The year commencing on January 1 and ending on December 31 of each year. For the purposes of this Administration Manual, the terms "Contract Year" and "Plan Year" are interchangeable.

Couple Coverage – Coverage for members and their eligible covered spouses.

Coverage Level – Single, parent plus, couple or family coverage.

Creditable Coverage - Prior coverage by a covered person under any of the following:
(A) a group health plan, including church and governmental plans;
(B) health insurance coverage;
(C) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
(D) Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act;
(E) the health plan for active and certain former military personnel, including CHAMPUS and TRICARE;
(F) the Indian Health Service or other tribal organization program;
(G) a state health benefits risk pool;
(H) the Federal Employees Health Benefits Program;
(I) a public health plan as defined in federal regulations**;**
(J) a health benefit plan under section 5(e) of the Peace Corps Act; and any other plan which provides comprehensive hospital, medical, and surgical services and meets federal requirements.

Creditable coverage does not include any of the following:

- accident only coverage, disability income insurance, or any combination thereof;
- supplemental coverage to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance;
- coverage for on-site medical clinics;
- benefits if offered separately:
  (1) limited scope dental and vision;
  (2) long-term care, nursing home care, home health care, community based care, or any combination thereof; and
  (3) other similar, limited benefits.
- benefits if offered as independent, non-coordinated benefits:
  (1) specified disease or illness coverage; and
  (2) hospital indemnity or other fixed indemnity insurance.
- benefits if offered as a separate policy:
  (1) Medicare Supplement insurance;
  (2) supplemental coverage to the health plan for active and certain former military personnel, including CHAMPUS and TRICARE; and
  (3) similar supplemental coverage provided to group health plan coverage.

Cross-Reference – A husband and wife who, as eligible employees of the KEHP, may elect to have both state paid contributions applied to their family coverage.

Dual Employment – Employees who work full-time for different agencies (i.e. school board and state agency) and who meet the eligibility requirements for both employers.

Effective Date – The date on which coverage for a covered person begins.

Eligible Person – A person who meets the eligibility requirements of the KEHP.

Employee – A person who is employed by agencies of the KEHP and eligible to apply for coverage under a KEHP.

Family Coverage – Coverage for the member, the member's spouse under a legally valid existing marriage and one or more dependent children.

Kentucky Employees Health Plan (KEHP) – The group, which is composed of eligible employees of state agencies, boards of education, health departments, quasi agencies, retirees of KCTCS, retirees of the Kentucky Retirement Systems, Teachers' Retirement System, the Legislators Retirement Plan and the Judicial Retirement Plan who are under age 65, and their eligible dependents.

Late Enrollee – An eligible person who requests enrollment in a plan after the initial open enrollment period. An individual shall not be considered a late enrollee if:

(a) The person enrolls during their initial enrollment period;
(b) The person enrolls during any annual open enrollment period; or
(c) The person enrolls during a special enrollment period.

Member – An employee, retiree or COBRA participant who is covered by one of the health plans offered by the KEHP.

Open Enrollment – a defined period of time, prior to the beginning of a Coverage Period during which an employee shall be entitled to elect benefit options for the subsequent coverage period.

Parent Plus – Coverage for the member and eligible dependents, except the spouse.

Plan Year – Each successive twelve-month period starting on January 1 and ending on December 31.

Premium – The periodic charges due which the member, or the member's group, must pay to maintain coverage.

Premium Due Date – The date on which a premium is due to maintain coverage under the KEHP.

Qualified Beneficiary – Any individual who, on the day before a COBRA QE, is covered under the Plan by virtue of being on that day a covered person, or any child who is born or placed for adoption with a member during a period of COBRA continuation coverage.

Qualifying Event – A specific situation or occurrence that enables an eligible person to enroll or terminate coverage outside the designated enrollment period as a result of that person becoming eligible for or losing eligibility for coverage under this Plan or another plan.

Retiree – A member of a retirement plan administered by the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, Legislators Retirement Plan, Judicial Retirement Plan or any other state retirement system, who is under age 65.

Single Coverage – Coverage for the member only.

Special Enrollment Period – A period of time during which an eligible person or dependent who loses other health insurance coverage or incurs a change in status may enroll in the plan without being considered a late enrollee.

SAMPLE
USE YOUR AGENCY LETTERHEAD

M E M O R A N D U M

TO: *(Employee)*

FROM: Insurance Coordinator

DATE:

SUBJECT: TEFRA for Active Employees Age 65 and Over

This letter is to inform an employee, nearing the age of 65, of his/her health insurance options upon becoming eligible for Medicare. As a result of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Medicare now supplements employer group health insurance plans. This means that if an employee elects coverage under the state sponsored health insurance plan, Medicare will pay benefits on a secondary basis.

MEDICARE

You will receive information regarding Medicare enrollment approximately three months prior to your 65th birthday. *If you are eligible* for Medicare Part A, the coverage will be free and enrollment will be automatic. Medicare Part B is **not** free and enrollment is **not** automatic. You are encouraged to contact your local Social Security office to determine your eligibility for these programs.

KENTUCKY EMPLOYEES HEALTH PLAN (KEHP)

Your Medicare eligibility or enrollment (Part A & Part B) does not affect your eligibility to continue coverage with the KEHP as long as you continue to meet the eligibility requirements as an employee. State sponsored plans offer the same health care coverage (under like conditions) to all active employees, regardless of age.

EMPLOYEE OPTIONS

Since you will be eligible to participate in Medicare and the KEHP, you should compare the cost of each, the benefits of each and make your decisions based upon your needs.

You may choose Medicare Parts A & B as your only source of coverage and waive your state sponsored health insurance. There is a monthly premium for Medicare Part B.

You may choose not to enroll in Medicare Part B and continue in the KEHP. The health insurance carrier will coordinate benefits with Medicare. You may delay enrollment in Medicare Part B until a later date, however, you will need to contact your local Social Security office regarding the Special Enrollment requirements, including dates.

Contact your local Social Security office or check the Centers for Medicare/Medicaid Services website* to obtain all the information necessary to make your decisions.

*http://cms.hhs.gov/default.asp?fromhcfadotgov=true

M E M O R A N D U M

TO: New Employees or Prospective Health Insurance Enrollees

FROM: (Name of State Agency, Board of Education, Local Health Department, KCTCS, etc.)

DATE:

NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for you, your spouse and/or any of your eligible dependents because of other health insurance coverage, you may be able to make a mid-year change in the Kentucky Employees Health Plan (KEHP) if you/they lose the other health coverage. If other health coverage is lost, you must request enrollment in the KEHP no later than thirty (30) days of the loss.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or the placement for adoption, you may be able to enroll yourself, your spouse, and/or your dependents in the KEHP, provided that you request enrollment within thirty (30) days of the date of the event. You will have sixty (60) days from the date of birth to add newborns or newly adopted or placed children. However, if you choose to add other eligible dependents at that time, the change must be made no later than thirty (30) days.

NOTICE ABOUT WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act requires the Commonwealth to notify you, as a participant in the KEHP, of your rights related to benefits provided through the program in connection with a mastectomy. You have rights to coverage provided in a manner determined in consultation with your attending physician for:

(1) all stages of reconstruction of the affected breast ;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the Plan's regular deductible, if any, and applicable co-payment or co-insurance amounts, depending upon the plan type and coverage option you have selected. For further details, please refer to your Summary Plan Description.

Keep this notice for your records.

Page Updated April 2008

2008 Health Insurance Checklist for New Employees

Name	Social Security Number
Agency Name	**Agency #**

Following is a list of your rights and responsibilities regarding the Kentucky Employees Health Plan (KEHP). Read this form carefully and make sure you understand each item. You may direct your questions to: _____ (your Insurance Coordinator) at _____. Or you may contact the Department for Employee Insurance at 888-581-8834 or 502-564-1205.

As a new employee, I understand that:

___ I have thirty (30) calendar days from my date of employment to make a health insurance election under the Kentucky Employees Health Plan (KEHP), which includes enrolling in a health insurance plan, flexible spending account and/or waiving coverage. The thirty (30) days are counted beginning with the day after my hire date. If I am an employee of an agency that has a different probationary period, I must sign and date my application no later than thirty (30) days prior to my coverage effective date.

___ I must submit all applications for health insurance (including a waiver of coverage) and Health Reimbursement Account/Flexible Spending Accounts to my agency's Insurance Coordinator or I must make my elections under the KEHP via Web Enrollment.

___ I will be subject to a one time, twelve (12) month waiting period for pre-existing conditions unless I have had prior creditable coverage for at least twelve (12) months and have had less than a sixty-three (63) consecutive day break in coverage between the termination of that coverage and the effective date of my coverage with the KEHP. Any prior period of coverage that is less than twelve (12) months will be applied against the pre-existing condition waiting period.

___ I must indicate my level of coverage on my application.
- SINGLE – Employee only
- PARENT PLUS – Employee and dependent child(ren)
- COUPLE – Employee and spouse
- FAMILY – Employee, spouse, and dependent child(ren)

___ Once I make my insurance elections, I can not change those elections for the plan year unless I experience a valid qualifying event or during the Open Enrollment period.

___ If I meet all requirements and elect to start a cross-reference payment option with my spouse, who is an existing employee of the KEHP, and one of us terminates employment, **the remaining employee will be responsible for the payment of the full family premium.**

___ If I fail to enroll within the specified deadline, I will be set up as a waiver with no Health Reimbursement Account. I will only be able to enroll in the KEHP if a qualifying event takes place that would allow me to enroll or during an Open Enrollment period.

___ Every year there is a defined Open Enrollment Period for health insurance that provides me the opportunity to make ANY type of change in my health insurance coverage and Health Reimbursement/Flexible Spending Account Program, if applicable.

NOTE: CHILDREN COVERED BY COURT ORDER OR ADMINISTRATIVE ORDER MAY NOT BE DROPPED FROM MY INSURANCE COVERAGE, EVEN DURING OPEN ENROLLMENT, UNLESS THERE IS A SUBSEQUENT COURT OR ADMINISTRATIVE ORDER.

___ Outside of the annual Open Enrollment Period, I will only be allowed to make changes to my current plan and, in appropriate circumstances, change plans **within thirty (30) calendar days of a qualifying event or up to sixty (60) calendar days for newborns and adoptions (see the Health Insurance Handbook for more information on adding newborns/adoptions and when they will be effective)**. A list of qualifying events is available from your Insurance Coordinator or the Personnel Cabinet's Web site at www.personnel.ky.gov inside the appropriate Summary Plan Description for your plan.

___ I have been directed to the Summary Plan Description on the Personnel Cabinet's website where I can find all relevant information pertaining to my insurance coverage.

___ It is my responsibility to sign and date the appropriate form requesting corresponding changes to my plan and give to my agency's Insurance Coordinator no later than thirty (30) calendar days of any event that may affect my coverage.

___ The State offers a Premium Conversion program that allows me to pay my portion of the health insurance premium with pre-tax dollars. I understand that I will automatically be enrolled in the program by virtue of enrolling in health insurance, unless I sign a cancellation form.

___ My coverage will begin no earlier than on the first day of the second month following my employment hire date.

___ If I experience a COBRA Qualifying Event, such as, but not limited to, termination of employment, I have the right to continue my health insurance at my own expense under COBRA.

___ If I decide that I do not want the state-sponsored health insurance at this time, I can waive (decline) coverage by completing the appropriate paperwork. If I waive coverage because I am covered under my spouse's plan, I will be allowed to enroll in a plan through the KEHP if one of the following occurs:

1. My spouse's employer group health insurance terminates;
2. Loss of eligibility;
3. If COBRA coverage is involved, the COBRA coverage expires;
4. My spouse's employer ceases contributing to the plan; or
5. Loss of a health insurance policy.

Check with your spouse's health plan before waiving coverage. Some companies will not cover you if you are eligible for health benefits through your own employer.

___ I may have the opportunity to enroll in the Flexible Spending Account (FSA) program, if applicable, no later than thirty (30) calendar days from my date of employment. I have obtained the appropriate FSA information and application and have been given a chance to ask questions pertaining to the coverage by my Insurance Coordinator.

___ I may contribute my own money into either the Health Care FSA or Dependent Care FSA. Once I have directed money into the Health Care FSA, changes are permitted for a HIPAA Special Enrollment Right or a Change in Status (Qualifying Event) if the change is requested no later than thirty (30) calendar days of the date of the event. Changes are allowed to the Dependent Care FSA with an approved Change in Status. Refer to the Qualifying Event Chart in your corresponding Summary Plan Description.

NOTE: NO QUALIFYING EVENT ALLOWS MEMBERS TO STOP HEALTH INSURANCE IN ORDERTO ENROLL IN A HEALTH REIMBURSEMENT ACCOUNT.

Have you worked for any other agency participating in the Kentucky Employees Health Plan within the last thirty (30) days?
Yes ___ No ___
If yes, please give name of agency and date terminated or transferred.

_____
_____/_____/_____
Agency **Last day worked**

Are you retired from a state-sponsored retirement system?
Yes ___ No ___
If yes, please specify which system:
_____Judicial Retirement Plan
_____Legislators Retirement Plan
_____KCTCS
_____Kentucky Retirement Systems
_____Kentucky Teachers' Retirement System

I acknowledge that I have received copies of the following:
_____*2008 Health Insurance Handbook* (includes Health Insurance Application)
_____Flexible Spending Account Information, if applicable
_____Initial COBRA letter
_____Memorandum regarding Notice of Special Enrollment Rights and Women's Health and Cancer Right Act (refer to Appendix B)
_____Summary Plan Description located at Personnel.ky.gov
_____Other _____

I certify that I have had my health insurance and Flexible Spending Account benefits explained and that I understand the benefits and my responsibilities.

_____ _____
Employee Signature **Date**

_____ _____
Agency Representative **Date**

Page Updated April 2008

SAMPLE

USE YOUR AGENCY LETTERHEAD

M E M O R A N D U M

TO: *(Employee on LWOP)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved LWOP

As an employee on Leave Without Pay (LWOP), you are eligible to continue your health insurance, flexible spending accounts, and any miscellaneous insurance(s) that you are having payroll deducted at your own expense if you lose your coverage under the Plan. You must contact *(Insurance Coordinator)* to make arrangements to continue your benefits coverage.

Health Insurance

To continue your group health insurance coverage you must pay the premiums to your agency or through COBRA. After you have been on LWOP for 30 or more working days and if you lose coverage under the Plan, you will receive a COBRA Notification Letter.

A. If you are on LWOP and you have pay during the month the leave starts, you will be eligible for the employer contribution for health insurance for the following month. However, if the pay you receive is not sufficient to cover the employee's portion of the premium, you will need to submit a check for the amount due.

   If you are on leave without pay and you do not have pay during a month, you will not be eligible for the employer contribution for health insurance for the following month. In this case, you must pay the total premium amount (employer and employee portion, if applicable) to continue your health insurance coverage.

   Any portion of a premium due by you must be submitted to the Insurance Coordinator by the 20th of the month. The check must be payable to the Kentucky State Treasurer and have your Social Security Number listed on the check. The Insurance Coordinator will forward the payment to the DEI.

   NOTE: If you fail to submit appropriate premium payments due within the specified deadline, the Plan may cancel the ENTIRE POLICY.

B. If you will be on LWOP for 30 or more days, you may continue your coverage through COBRA if you lose coverage under the Plan. You will need to fill out the COBRA election form and submit it, with your payment, to Ceridian. Follow the instructions provided with your COBRA materials.

Health Care Flexible Spending Account

If you are eligible and you decide to continue your participation in the Health Care FSA, you must submit a check to your Insurance Coordinator, in the amount of $_____ made payable to the Kentucky State Treasurer**.** If you do not continue this contribution while on LWOP, you will **not** be eligible to participate in the program for the remainder of the plan year once you return to work.

Miscellaneous Insurances (payroll deducted)

To continue your miscellaneous insurances that you are having payroll deducted, send payments directly to the insuring agency. Our records indicate that you have the following additional insurance and/or deductions:

(List payroll deductions)

When you return to work after being on LWOP you must work at least one day in the month you return to be eligible to receive the employer contribution for health insurance for the following month. If you do not work one or more days in the month you return, the first day of the second month rule applies regarding your effective date of your health insurance.

When you return from LWOP your length of absence may affect your health insurance. If you do not elect to continue health insurance while on LWOP, and have more than a 63 day break in coverage, you will be subject to pre-existing conditions when your coverage resumes.

When you return to work after being on LWOP you will not be eligible to make any changes to the health insurance coverage in which you were enrolled prior to the LWOP unless one of the following has occurred:

- You experience a QE and you apply for an appropriate change within thirty (30) days of returning to work, except when adding a child ONLY due to birth, adoption, or placement for adoption, which would require you to apply within sixty (60) days.

- You return in a new plan year or after missing the Open Enrollment period and you apply for a coverage change no later than thirty (30) days after your return.

- The coverage in which you were enrolled prior to the beginning of the LWOP is not available upon your return. You will have no more than thirty (30) days after your return to apply for an appropriate change.

The Insurance Coordinator must provide the necessary applications upon return.

Should you have any questions, you may contact me at _____.

Page Updated April 2008

SAMPLE

USE YOUR AGENCY LETTERHEAD

MEMORANDUM

TO: *(Employee on Family Leave)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved Family Leave

This letter is to inform you of your health insurance responsibilities as an employee on family leave. As an employee on Family Leave, the state will continue to make the employer contributions for your health insurance or health reimbursement account, if applicable. It is your responsibility to make timely payments of any employee contribution amounts that had previously been deducted for health insurance or for flexible spending accounts.

Health Insurance

While on family leave, two conditions must be met in order to qualify for the employer contribution for health insurance. The first is you must maintain the level of coverage that was in effect before going on leave. Secondly, you must pay the employee contribution, if applicable. To continue your health insurance you must submit a check made payable to the Kentucky State Treasurer, in the amount of $_____ (employee contribution).

Flexible Spending Account *(if applicable)*

If you are enrolled in the Kentucky Employees Health Plan Flexible Spending Account Program and you contribute your own money (employee contribution), you may submit a check in the amount of $_____ made payable to the Kentucky State Treasurer. If you choose not to continue the employee contribution, the annual contribution amount will be adjusted accordingly. If you wish to resume your employee contribution when you return from family leave, you must complete a new enrollment form.

The payments for health insurance and Flexible Spending Accounts should be submitted to the following address by the 10th of each month. Please include your Social Security Number on each check.

_____

_____

_____

Miscellaneous Insurances (payroll deducted)

All other insurances and deductions made from your paycheck will cease unless timely payments are made. You should contact the agency directly. Our records indicate that you have the following additional insurance and/or deductions:

(List payroll deductions)

If you exhaust your family leave time before you are able to return to work and you are eligible, you will be sent a COBRA notification letter, which allows you to continue your health insurance totally at your own expense. Should you opt not to continue under COBRA, you will be restored to your previous level of coverage immediately upon your return to work.

If you have any questions, please feel free to contact me at _____.

Personnel Cabinet
Department for Employee Insurance

2008 Health Insurance Total Monthly Premiums

	Single	Couple	Parent Plus	Family
Commonwealth Essential	N/A	$947.44	$617.12	$1,056.56
Commonwealth Enhanced	$484.24	$1,137.18	$742.74	$1,267.40
Commonwealth Premier	$501.20	$1,175.32	$772.06	$1,309.76
Commonwealth Select	$469.00	$989.18	$703.50	$1,128.48

Employee Contributions

Monthly Employee Contribution* – Non-Smoker

	Single	Couple	Parent Plus	Family	Family Cross-Reference*
Commonwealth Essential	Not offered	$290.84	$61.64	$358.80	$0
Commonwealth Enhanced	$0	$400.90	$127.76	$481.10	$10.90
Commonwealth Premier	$20.40	$446.80	$190.94	$532.08	$37.08
Commonwealth Select	$0	$302.10	$98.26	$361.38	$8.18

Monthly Employee Contribution* – Smoker

	Single	Couple	Parent Plus	Family	Family Cross-Reference*
Commonwealth Essential	Not offered	$324.48	$95.26	$392.42	$16.80
Commonwealth Enhanced	$16.80	$434.52	$161.38	$514.72	$27.70
Commonwealth Premier	$37.20	$480.42	$224.56	$565.70	$53.88
Commonwealth Select	$13.22	$327.44	$124.12	$386.66	$20.80

* Contribution is per employee

Page Updated April 2008

Page Updated April 2008

2008 COBRA Rates

	Single	Parent Plus	Couple	Family
Commonwealth Essential	Not Offered	$629.46	$966.39	$1,077.69
Commonwealth Enhanced	$493.92	$757.59	$1,159.92	$1,292.75
Commonwealth Premier	$511.22	$787.50	$1,198.83	$1,335.96
Commonwealth Select	$478.40	$717.58	$1,008.96	$1,151.05
HRA Waiver	$169.58			

Page Updated April 2008

2008 COBRA Calendar

QUALIFYING EVENT DATE	18 MONTHS	36 MONTHS
12/07	06/30/2009	12/31/2010
01/08	07/31/2009	01/31/2011
02/08	08/31/2009	02/28/2011
03/08	09/30/2009	03/31/2011
04/08	10/31/2009	04/30/2011
05/08	11/30/2009	05/31/2011
06/08	12/31/2009	06/30/2011
07/08	01/31/2010	07/31/2011
08/08	02/28/2010	08/31/2011
09/08	03/31/2010	09/30/2011
10/08	04/30/2010	10/31/2011
11/08	05/31/2010	11/30/2011
12/08	06/30/2010	12/31/2011

County and Group Number Table

FIPS	CO. NO.	COUNTY NAME	AREA	GROUP NO.
001	001	ADAIR	LEX	P6070
003	002	ALLEN	LOU	P5941
005	003	ANDERSON	LEX	P6070
007	004	BALLARD	LOU	P5941
009	005	BARREN	LOU	P5941
011	006	BATH	LEX	P6070
013	007	BELL	LEX	P6070
015	008	BOONE	N.KY	P6070
017	009	BOURBON	LEX	P6070
019	010	BOYD	LEX	P6070
021	011	BOYLE	LEX	P6070
023	012	BRACKEN	LEX	P6070
025	013	BREATHITT	LEX	P6070
027	014	BRECKINRIDGE	LOU	P5941
029	015	BULLITT	LOU	P5941
031	016	BUTLER	LOU	P5941
033	017	CALDWELL	LOU	P5941
035	018	CALLOWAY	LOU	P5941
037	019	CAMPBELL	N.KY	P6070
039	020	CARLISLE	LOU	P5941
041	021	CARROLL	LOU	P5941
043	022	CARTER	LEX	P6070
045	023	CASEY	LEX	P6070
047	024	CHRISTIAN	LOU	P5941
049	025	CLARK	LEX	P6070
051	026	CLAY	LEX	P6070
053	027	CLINTON	LEX	P6070
055	028	CRITTENDEN	LOU	P5941
057	029	CUMBERLAND	LEX	P6070
059	030	DAVIESS	LOU	P5941
061	031	EDMONSON	LOU	P5941
063	032	ELLIOTT	LEX	P6070
065	033	ESTILL	LEX	P6070
067	034	FAYETTE	LEX	P6070
069	035	FLEMING	LEX	P6070
071	036	FLOYD	LEX	P6070
073	037	FRANKLIN	LEX	P6070
075	038	FULTON	LOU	P5941
077	039	GALLATIN	N.KY	P6070
079	040	GARRARD	LEX	P6070
081	041	GRANT	N.KY	P6070
083	042	GRAVES	LOU	P5941
085	043	GRAYSON	LOU	P5941
121	061	KNOX	LEX	P6070
123	062	LARUE	LOU	P5941
125	063	LAUREL	LEX	P6070
127	064	LAWRENCE	LEX	P6070
129	065	LEE	LEX	P6070
131	066	LESLIE	LEX	P6070
133	067	LETCHER	LEX	P6070
135	068	LEWIS	LEX	P6070
137	069	LINCOLN	LEX	P6070
139	070	LIVINGSTON	LOU	P5941
141	071	LOGAN	LOU	P5941
143	072	LYON	LOU	P5941
151	076	MADISON	LEX	P6070
153	077	MAGOFFIN	LEX	P6070
155	078	MARION	LOU	P5941
157	079	MARSHALL	LOU	P5941
159	080	MARTIN	LEX	P6070
161	081	MASON	LEX	P6070
145	073	MCCRACKEN	LOU	P5941
147	074	MCCREARY	LEX	P6070
149	075	MCLEAN	LOU	P5941
163	082	MEADE	LOU	P5941
165	083	MEIFEE	LEX	P6070
167	084	MERCER	LEX	P6070
169	085	METCALFE	LOU	P5941
171	086	MONROE	LOU	P5941
173	087	MONTGOMERY	LEX	P6070
175	088	MORGAN	LEX	P6070
177	089	MUHLENBURG	LOU	P5941
179	090	NELSON	LOU	P5941
181	091	NICHOLAS	LEX	P6070
183	092	OHIO	LOU	P5941
185	093	OLDHAM	LOU	P5941
187	094	OWEN	LEX	P6070
189	095	OWSLEY	LEX	P6070
191	096	PENDLETON	N.KY	P6070
193	097	PERRY	LEX	P6070
195	098	PIKE	LEX	P6070
197	099	POWELL	LEX	P6070
199	100	PULASKI	LEX	P6070
201	101	ROBERTSON	LEX	P6070
203	102	ROCKCASTLE	LEX	P6070
205	103	ROWAN	LEX	P6070

FIPS	CO. NO.	COUNTY NAME	AREA	GROUP NO.
087	044	GREEN	LOU	P5941
089	045	GREENUP	LEX	P6070
091	046	HANDCOCK	LOU	P5941
093	047	HARDIN	LOU	P5941
095	048	HARLAN	LEX	P6070
097	049	HARRISON	LEX	P6070
099	050	HART	LOU	P5941
101	051	HENDERSON	LOU	P5941
103	052	HENRY	LOU	P5941
105	053	HICKMAN	LOU	P5941
107	054	HOPKINS	LOU	P5941
109	055	JACKSON	LEX	P6070
111	056	JEFFERSON	LOU	P5941
113	057	JESSAMINE	LEX	P6070
115	058	JOHNSON	LEX	P6070
117	059	KENTON	N.KY	P6070
119	060	KNOTT	LEX	P6070
207	104	RUSSELL	LEX	P6070
209	105	SCOTT	LEX	P6070
211	106	SHELBY	LOU	P5941
213	107	SIMPSON	LOU	P5941
215	108	SPENCER	LOU	P5941
217	109	TAYLOR	LOU	P5941
219	110	TODD	LOU	P5941
221	111	TRIGG	LOU	P5941
223	112	TRIMBLE	LOU	P5941
225	113	UNION	LOU	P5941
227	114	WARREN	LOU	P5941
229	115	WASHINGTON	LOU	P5941
231	116	WAYNE	LEX	P6070
233	117	WEBSTER	LOU	P5941
235	118	WHITLEY	LEX	P6070
237	119	WOLFE	LEX	P6070
239	120	WOODFORD	LEX	P6070

2008 Humana Carrier Codes

	Group #	Group #	Group #
	P5941	**P6070**	**P6077**
	Louisville Area	Lexington Area	No.Ky/Cinci Area
Commonwealth Essential	**CHLJ**	**CHMM**	**CHNP**
Commonwealth Enhanced	**CHL9**	**CHNC**	**CHOF**
Commonwealth Premier	**CHLW**	**CHMZ**	**CHN2**
Commonwealth Select	**DAI1**	**DAJE**	**DAJR**
Waiver HRA	**DJ4A**	**DJ3X**	**DJ4N**